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HABIT CLINICS No. 131-R
FOR CHILD GUIDANCE 1938

CHILDREN'S BUREAU—U. S. DEPARTMENT OF LABOR

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UNITED STATES DEPARTMENT OF LABOR

FRANCES PERKINS, Secretary

CHILDREN'S BUREAU

KATHARINE F. LENROOT, Chief

HABIT CLINICS FOR CHILD GUIDANCE

BY

D. A. THOM, M. D.



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CONTENTS

	Page
Letter of transmittal.....	v
Introduction.....	1
Habit-clinic personnel and procedure.....	5
The psychiatrist.....	5
The psychologist.....	7
The social worker.....	12
Habit-clinic procedure.....	15
Cooperation with other community agencies.....	22
The child and his personality.....	24
The parent and the home.....	28
Habit problems associated with eating, sleeping, and elimination.....	33
Eating habits.....	33
Habits of elimination.....	39
Habits of sleep.....	43
Resentment towards frustration expressed in aggressive acts.....	47
Anger and temper tantrums.....	48
Destructiveness.....	55
Delinquency.....	59
Retreat as a method of meeting failure.....	70
Problems associated with the development of the child's sex life.....	76
Personality changes following illness and injury.....	82
Convulsions, tics, mannerisms.....	86
The crippled child.....	90
Mental deficiency.....	93
Conclusion.....	96

LETTER OF TRANSMITTAL

UNITED STATES DEPARTMENT OF LABOR,
CHILDREN'S BUREAU,
Washington, November 23, 1938.

MADAM: There is transmitted herewith a revised edition of *Habit Clinics for Child Guidance*, first published in 1923 as *Habit Clinics for the Child of Preschool Age*, by Dr. D. A. Thom, director of the habit clinics of the Community Health Association of Boston and director of the division of mental hygiene in the Department of Mental Diseases of Massachusetts.

The revision is an enlargement of the original edition, based on Dr. Thom's experience in the habit clinics over the past 15 years. It is believed that the method developed by Dr. Thom and here set forth will be of interest to all concerned with the physical and mental health of children.

Respectfully submitted.

KATHARINE F. LENROOT, *Chief.*

HON. FRANCES PERKINS,
Secretary of Labor.

HABIT CLINICS FOR CHILD GUIDANCE

INTRODUCTION

Fifteen years have elapsed since the Children's Bureau published a report entitled, "Habit Clinics for the Child of Preschool Age; their organization and practical value." This report was the first of its kind and embodied what at that time represented a fairly comprehensive review of the organization and development of the first clinic in this country to deal specifically with the mental health of the preschool child.

Since the preschool period is the habit-forming period, this clinic was called a habit clinic. It was felt that there was a real need for this subject of the mental health of the child to be presented to parents, teachers, nurses, and general practitioners in a way that could be utilized by these various groups in their everyday contact with children. It was therefore not considered within the scope of the publication to discuss the psychological mechanisms which motivated the type of conduct that brought children into conflict with the group or rendered them unhappy and inefficient. The author has repeatedly stressed the need of reducing mental hygiene to terms that would have a practical value to those individuals making daily contact with children. The last 10 years have borne witness to the fact that those mental-health clinics which have rendered a real service to the community—that is, to the home, the school, the hospital, the medical clinic, and organizations concerned with child welfare—have survived. They have created for themselves a place of importance in the fields of parent education, pedagogy, and medicine.

It has now seemed wise to revise the report in order that it may be more useful to those interested in this field.

In the revision the name habit clinic has again been used rather than child-guidance clinic, as the publication is concerned primarily with preschool children and many of the problems of older children, dealt with in most child-guidance clinics, are not discussed. The following discussion will be open to the criticism of being rather superficial and lacking the precise technique necessary for the solution of many of the more complex problems with which parents are confronted. It may be said, however, that in dealing with these obviously more involved situations, parents must necessarily seek help from those who have had training and experience in this particular field. Parents do not treat fractures or serious infections, nor do they attempt surgical procedures; neither are they equipped to solve the more serious problems pertaining to the mental health of the

child. Experience, however, has led us to believe that the parent, the teacher, the nurse, and the general practitioner are in a position to render valuable first aid. They can prevent the development of many serious mental problems if they are equipped with such knowledge of mental hygiene as falls well within their grasp.

From a practical point of view there is a large group of cases which will benefit from the understanding and guidance that can be given directly in the home, where the problem originates. It is recognized that there are exceptional cases so complicated and involved that they will tax the skill and ingenuity of the specialist. The outstanding question is how the clinic can best serve the community in which it is located, the health agency with which it may be affiliated, and the school and social agencies which are dependent upon it for advice and treatment. Its function is not limited to the treatment of individual cases but should include, for educational purposes, the dissemination of such knowledge as has been acquired by experience.

In the organization and development of clinics it is necessary to be practical, and this requires that one evaluate the total situation. A physician, a social worker, or a nurse may complicate a home situation instead of helping it unless the family rather than the individual is kept in mind as the unit. For example, it may be much easier for the mother of five children to wash extra sheets three or four times a week than to bring a youngster afflicted with enuresis to the clinic the same number of times. On the other hand, much may be accomplished with only the minimum of inconvenience to the mother if a weekly clinic visit is made. Without minimizing the value of intensive work or implying that one method will be applicable to every case, it may be pointed out that many of the problems presented at the habit clinics have been treated successfully by merely directing attention to something that was obviously wrong in the environment. In other words, there was no need to use a pick and shovel when a rake would do the work. An important causative factor may easily be overlooked by parents, a nurse, or even the family physician, and yet be quite apparent to a well-trained psychiatrist.

Inasmuch as the behavior of the child represents the response which that particular individual makes to his environment, the clinic must have first-hand knowledge of this environment. An irreducible minimum for an investigation should be outlined and carefully followed in every case in order that important environmental situations directly affecting the conduct of the child may not be overlooked. This part of the clinic program should be carried out by a well-trained social worker, who, by virtue of her training, is in a position not only to describe environmental situations but also to interpret to the psychiatrist how these particular situations are affecting the child. She must be in a position to evaluate the social, economic, cultural, and intellectual level of the child's home and the surrounding conditions, the personalities with whom the child has to deal, and the adjustment of these personalities to one another. She must bring to the attention of the clinic the facilities in the community that can be utilized in helping the child to make a better social adjustment.

In order to understand the behavior of the child, an appreciation of the intellectual differences in children is also necessary. This

part of the program is in the hands of the *psychologist*, who obtains the information relative to the child's mental equipment, his attitude toward work, his ability to concentrate, and his particular interests and aptitudes. The *psychiatrist* must take all the available information, together with the material gathered from his direct personal contact with the child and the parents, interpret this information, and utilize it in making a plan. This plan must take into consideration not only the particular problem for which the child was brought to the clinic but the child's adjustment to life in general.

Although a clinic for child guidance is concerned with the child, the family must be considered as a unit. Where there is a problem child, not infrequently the mother, father, brother, sister, or some other relative represents the offending aspect of the environment. It is likely that certain parental attitudes need to be altered. Perhaps the behavior of a problem brother or sister must be treated. A change in schools may be necessary. Foster parents may have to be introduced as a temporary expedient. Possibly help must be sought from social agencies interested in relief, placement, and observation of children under supervision. It is not unusual to find that the child who has been brought to the clinic is not the one who is most in need of treatment. The shy, diffident, well-mannered child in grave need of help may have been left at home while his much better-adjusted, tempestuous brother who causes his parents annoyance has been brought for help. It frequently happens that two or three members of the same family receive clinic treatment at the same time or that several members of the same family benefit by the treatment which one maladjusted member receives at the clinic.

Mental hygiene has made great strides during the last 10 years, and the general public is very much better informed about the importance and value of mental health. The time has already arrived when the larger social agencies are finding it necessary to have upon their staffs someone well trained in child-guidance work. Already such agencies have clinics for both children and adults. It has become an absolute necessity for all organizations dealing with the problems of human beings, whether it is with reference to disease, poverty, or delinquency, to have some knowledge of mental hygiene. The necessity of recognizing the importance of mental health has been stressed by the leaders in the fields of sociology, penology, industry, and education.

There is still a long way to go, however, before parents in general will be as deeply concerned over defects in personality and over undesirable habits as they are over physical ailments. There are advantages in small, informal clinics wherever they can be established in the community as an adjunct to highly organized mental-health clinics which are always available for service. The ideal place for one of these clinics concerned with the mental health of preschool children is in association with other services for children, especially general health clinics. A clinic serving preschool children and some older children can be assimilated easily by a health center and it can operate as part of the medical routine. There must be some more highly organized mental-health centers here and there, with opportunities for research work and training. A medical background is absolutely essential to clinics interested in mental health. Every

child must have a careful physical examination, and all abnormal conditions having a physical basis should be corrected before any attempt is made to interpret the symptoms on a psychogenic basis. There is no branch of medicine in which greater care is needed to prevent the introduction of all sorts of quacks and charlatans than psychiatry. The association of a mental-health clinic with a recognized medical organization stamps its work as part of a well-rounded and well-qualified medical program.

The simplicity of such an organization has much to recommend it. It has the advantage of offering to a community a service that is as vital to its welfare as the school or the hospital. It offers to the parent, the nurse, and the teacher valuable aid in developing a happier and more efficient group of children. It permits the individual child who is momentarily out of adjustment with life the opportunity of understanding himself as well as being understood by those upon whom he is dependent for his rehabilitation.

HABIT-CLINIC PERSONNEL AND PROCEDURE

In the routine clinical procedure of the habit clinic the close co-operation between the psychiatrist, the psychologist, and the social worker will be stressed repeatedly. Although each has a specific job in which he excels, there is no sharp line of demarcation. In fact, an occasional invasion of one into the territory of the other is to be desired.

It is the function of the clinic and the purpose of the combined groups to make a careful investigation and study of the child's behavior, his mental attitudes, and his personality deviations, and to evaluate his assets as well as his liabilities. It is the purpose of such an approach to understand and eventually to straighten out asocial and undesirable tendencies before they become a fixed part of the child's personality make-up. If this is done many children will approach adolescent and adult life unhampered by the crippling influences of their early training and unhappy experiences. There is reason to believe that a relationship exists between the emotional instabilities and conduct disorders of early life and the problems of delinquency and neurotic disturbances later on.

THE PSYCHIATRIST

The psychiatrist is the logical person to act as the director of any clinic whose function is to study and treat behavior problems. He is a medically trained person who has specialized in mental health. Hence, he not only is concerned with behavior as it affects the individual's conduct in relation to the community but is also seeking the motivating forces which lie behind those inner conflicts leading to unhappiness and inefficiency. Only a medically trained person who has also had training in psychiatry is qualified to decide which cases need physical treatment and which cases can be helped only by psychotherapy. He must also see that cases needing both types of treatment are adequately cared for.

The psychiatrist is dependent upon others of the clinic group for complete understanding of the child. He needs information from them in order to outline treatment and see that the child is properly supervised. Details of therapy may be carried on to advantage by the psychologist, the social worker, or the speech worker, but the final decision should rest with the psychiatrist. A well-organized clinic group will have no difficulty in determining just where each individual fits in best if the prevailing spirit is one of cooperation.

The psychiatric interview must be so conducted that the parent feels at ease. (See case presented in section on Habit Clinic Procedure—Interview With Psychiatrist, p. 17.) The psychiatrist should try to win the confidence of the parent. This can be done only if the parent is convinced that the doctor is interested in understanding the problems confronting the child and those of the parents as well. It is

fair to assume that if the parents are making mistakes in the training of their children, they are not doing so willfully and viciously. They are without doubt anxious to discover what mistakes they are making and why they are prone to make these particular errors. It tends to build up a parent's self-esteem and make him feel capable of carrying out the details of treatment if the psychiatrist and the other clinic workers treat him as a responsible being. There is danger, at times, that the psychiatrist will take advantage of his position as the one in authority. By a critical, unsympathetic attitude he will humiliate parents with all the obvious mistakes which they have made. He will send them away from the clinic more discouraged and less able to cope with their problem than when they came. It is a very delicate piece of work to deal with a mother who has been a failure with her child (for this is often the problem), especially if one has to point out the seriousness of the difficulty as well as the difficulty itself. It is in this respect that the habit clinic differs from most agencies. Hospitals, schools, and many other organizations have the law behind them, or if not the law, the fear of death or destitution, or an actual and conscious want, and they afford concrete and tangible assistance. The habit clinic has no definite authority but has to depend for its cooperation upon the parental instinct and a friendly contact, and its assistance is at times very subtle and intangible.

The psychiatrist examines all the information which he himself has collected from his interviews with parent and child, together with that obtained by the social worker and the psychologist and from medical reports. He then attempts to interpret the child's behavior in terms of his personality make-up and his environment. Here is where the psychiatrist tries to apply to this child his knowledge about children in general. He is seeking to determine the hopes, interests, ambitions, love attachments, grudges, fears, and disappointments which have created conflicts within the child himself. He seeks to discover just how these conflicts have affected the child and his relationship with the world in which he lives. He is concerned with what can be done with those environmental situations which create emotional turmoil in the child. Parents are by far the most important influence in the child's environment, and so it is their attitudes that cause the psychiatrist the greatest concern. The conditions and relationships in the school and the neighborhood are likewise important, as is the social, economic, and moral status of the family in their particular community.

The relationship between the psychiatrist and the child is one that requires time, patience, judgment, and understanding. The psychiatrist has no instruments with which to measure resentment, humiliation, fear, jealousy, and other less well-defined attitudes which the child may be experiencing. We know that the child who is in conflict with himself and his environment is usually unhappy. He is not satisfied with his lying, stealing, or truancy. Rarely is it an end in itself; it is merely a means of escape from some situation which is felt to be intolerable. It is with these intangible problems that the psychiatrist has to deal, using such understanding as his experience, education, and training permit. Perhaps his success is due

more to his inherent wisdom and ability to understand the motives that actuate human behavior than to his psychiatric knowledge. Both are essential if one is to succeed in being helpful to the child in trouble and to his worried, harassed parents.

In the majority of cases the results are good. In some the improvement is quick and very marked—in the mother's eyes a miracle. In others the progress is slow and the condition is complicated and not fully appreciated by the mother, who takes the attitude either that it is useless to come to the clinic as the child is not improving, or that the problem is too unimportant to bother with. In either case there must be frequent calls at the home in order to educate the mother and insure the proper following out of the treatment. Sooner or later these children show the effect of the work done upon them, and the mothers express their gratitude. It is in these cases that the social services are most important, as the results depend upon careful, persistent, tactful work that means not merely a series of calls but a program of education.

It is essential that the psychiatrist who deals with the behavior disorders of childhood should be optimistic as well as patient. All too frequently many of the problems which are brought to the clinic have been in the making for a long time. These habits have become firmly fixed, and they are very much a part of the individual. Attitudes built up as the result of long-continued, unhappy experiences are not eradicated easily. The psychiatrist must devote weeks, months, and sometimes years to the treatment of a single case. At times he must even acknowledge failure. Yet he must always think in terms of the future and in terms of success.

THE PSYCHOLOGIST

The duties of a psychologist in a clinic devoted mainly to the problems of preschool children are many and varied. What they are will depend upon the problems of the individual children seeking clinical help. At one time his function may be to determine the level of mental development that the child has reached; at another, to throw some light upon the reason for slow language development; or yet again, to give advice upon some school problem, of which there are many. Since the contact of the psychologist with the child usually covers a long period, he is in a position to observe any special handicap that the child may have. Loss of hearing, defective eyesight, inarticulate speech is sometimes discovered; even a peculiar mannerism may sometimes serve as a clue to some more obscure difficulty which leads to the child's being directed to the right sources for care and treatment.

When one seeks to reconstruct the behavior of a child by the formation of correct habits, much depends upon the child himself. One of the first questions that confronts a worker is the native ability of the child, or in other words, how much may be expected of him in the reeducational process. It is to the psychologist with his specialized training that one looks for an answer to this question.

The various studies made in recent years upon the development of child life indicate that mental development proceeds in an orderly, continuous way. A child must attain the lower mental levels before

going on to the higher. By administering and interpreting many standardized tests now available it is possible to determine different age levels. Has the child reached a level that one of his age usually reaches, or has his mental growth failed to keep pace with his chronological years? On the other hand, has his mental age gone beyond his chronological years? It is essential that these fundamental questions be answered first, for many problems arise through ignorance of these facts alone. To expect a child to function on a level of which he is not intellectually capable only brings strain and stress to both child and parent. On the other hand, many problems are often created by failure to recognize that a child's mental development is beyond his chronological age. A few cases will illustrate this.

Sylvia is a child whose mental development has not kept pace with her years of living. At 6 years 8 months she was brought to a clinic primarily for her many fears. Fears of animals, of strangers, and of school were among them. There were other problems of stubbornness, temper tantrums, and too much dependence upon her mother. She had entered the first grade in the public school but was soon excluded because of her peculiar behavior. She gave no attention to the subjects presented but wandered around aimlessly, talking to herself.

Careful study of Sylvia showed a high degree of mental retardation. In most respects she was capable of doing no more than the average 4-year-old child is able to do. Expecting her to hold her place with children some 2 years in advance of her mentally, necessarily led to difficulties. Furthermore, in the treatment of any of Sylvia's problems one will have to keep in mind the immaturity of the child and expect no more of her than she can attain.

Jean represents a child whose difficulties were due in part to advanced mental development. Poor adjustment to kindergarten, a strong desire to dominate, and resistance to authority were some of the problems for which her parents sought clinical guidance. Although Jean's chronological age was only 5 years 8 months, tests indicated that she was over 8 years in her mental development. She was recognized by both parents and teachers as a bright child, but at no time had her true ability been recognized. It can readily be seen why Jean did not find school work on a kindergarten level interesting.

Slow speech development is a problem which usually gives a parent much concern. Many children are brought to a clinic for this reason alone. With such a case, the role of the psychologist is very important. It may even be that the problem is solved by the psychological study alone, for tests may determine that the child has not reached the mental age at which speech develops. The speech retardation may prove to be only a part of the child's general retardation.

The services of the clinic were consulted in regard to Celia's slow speech development. She was 6 years 3 months of age and had begun her first-grade work in school. From this she was soon dropped. Two older sisters were spending much time trying to teach her but with little success. In spite of their effort Celia had only a few words at her command. Her problem was soon solved, for all tests showed that Celia had not reached the mental age at which speech develops. Her slowness in talking could be explained by a mental retardation below the age at which a child begins to use language.

There may be other reasons why a child is not learning to talk. Chief of these is deafness or loss of hearing.

Grace represents such a case. At 4 years of age she had acquired scarcely any vocabulary. Several tantrums at times made it difficult for the parents to discipline her. In the tests that could be given her at the clinic she re-

sponded like a child of average intelligence. However, her behavior suggested deafness, and a hearing test was recommended. Audiograms showed that the child suffered from marked impairment of hearing. In this case slowness in learning to talk was due to deafness and called for very different treatment from that of a child whose poor speech is due to mental retardation.

Proper school placement is of great importance for the mental health of the child. School failure should be avoided whenever possible. Formerly little attention was paid to a child until he had failed two or three times. Attempts are now in progress to make such adjustments much earlier, with the result that the clinic services are often consulted when it looks as if the child will not make the grade during the first year. In this way, failure, with its emotional effects, is often averted. More enlightened mothers are even bringing their children to the clinic to determine their readiness and fitness for school. For these problems the services of the psychologist are very necessary.

Robert was a little chap whose age allowed him to enter the first grade. His mother questioned his readiness and came to the clinic seeking advice. All tests confirmed the mother's suspicions. Robert was slow in his development and was in every respect a much younger child than his chronological years. His poor ability in some special things gave every reason to believe that Robert would fail if he began his first-grade work at that time.

Proper school placement was a matter of concern to Richard's mother also. She was aware that he read well for a child only 6 years 3 months of age, but she questioned his ability to do second-grade work without spending the first year in school. The clinic was consulted. Richard's advanced mental development, together with the fact that educational tests showed his preparedness for second-grade work, justified his going into that grade. He was advanced to the second grade, where he adjusted himself easily and happily.

These cases represent only a few of the many problems coming to the clinic in which the services of a psychologist are essential. Furthermore, because the work is varied and demanding, it is important that only those who have had adequate training and experience should assume the responsibility of doing the work. The qualifications of a clinical psychologist should comprise more than a mere knowledge of the technique of administering the tests and the ability to compute the intelligence quotient. Determining the intelligence quotient is but a small part of the psychological study and means little unless interpreted in relation to good developmental, medical, and social history of the child. Personality traits, handicaps, if any, and special abilities or disabilities also come in for study. Only one who is familiar with these various aspects of a child's development can ever hope to do justice to the child in such a study.

After the intelligence quotient has been determined, a question which one may reasonably ask is whether the intelligence quotient remains constant or relatively the same throughout life. Though the constancy of the intelligence quotient has been studied extensively, the question is not definitely settled at the present time. The age at which the psychological study is made will influence somewhat the intelligence rating. To a clinical psychologist who has worked with a young child before his language has developed to any extent it is not surprising to find that the child has raised his rating perceptibly at a later date. Also, a child from a poor environment may change his scoring when placed for a while under better circumstances.

However, an experienced worker will recognize the potentialities of development and differentiate between what may be a permanent retardation and an underdevelopment due to poor environment.

The whole subject of a psychological study might be best understood by pointing out some of the many interesting facts that may come to light during an examination. The first requirements are proper rapport between the psychologist and the child and establishment of a proper attitude toward the tests in general. The psychologist gets his first knowledge of the child from the way in which the situation is met. With one child rapport is quickly established. He comes readily and alone with the examiner to the examining room. He may be a little shy at the beginning but he soon learns that the examiner is a friend and not someone to be feared. In a short time he is very much at ease and complies with all requests. He works with effort and persistence and meets the most difficult test even though his efforts may not be crowned with success. His attitude is one of independence and of meeting new situations alone and unaided.

With another child the very opposite may be true. His mother may have to accompany him to the examining room; he remains fearful of the examiner throughout the examination; he is never at ease; he responds to tests largely under protest; his effort is poor; and when he meets the slightest difficulty he appeals for help. In fact, his attitude is one of dependence and a constant seeking for assistance. At no time does he meet the new situation independently and unaided. In truth, the response to the test situation may often be an indication of the way the child is meeting life in general.

When the child's cooperation has been obtained, the more formal tests are given. The object of the standardized test is to determine how the child's development compares with that of other children of his age. If he has not come up to the standard, what are some of the factors that may possibly affect his future development? One must allow for the premature child to catch up to his actual age; for the child whose physical activities have been curtailed because of many illnesses; for the child with a birth injury; and for children with other handicaps. Handedness also may be observed at this time. At an early age the child begins to show a preference for the use of one hand. Interference in the development of the use of the hands may work out disadvantageously to the child. The little child who has been forcibly changed from the use of the preferred left hand to that of the right is all too frequently recognized by other signs of difficulty.

Further insight into the child's mental development is had by the use of language tests. There is no phase of development that requires more careful observation and study. To distinguish between good all-round language development and mere superficial verbalistic fluency is possible only to one who has a knowledge of language tests and experience with children who show various phases of speech acceleration or retardation. It may be said that this phase of development can be most misleading. The child who speaks a great deal and at an early age is generally regarded as intellectually superior, but this impression may or may not be correct. On the other hand, the child with poor enunciation and little facility in the use

of words is often considered retarded. These deductions may or may not be true, depending upon the nature of the language development.

The type of child who has only a parrotlike speech development is well known to the clinical psychologist. He enunciates clearly and has several language patterns. When using these freely and spontaneously, and in the manner in which he has learned them, he seems quite like the average child. He fails, however, when he is asked to use these words in a new way or to show that he knows what they mean.

Daniel's history illustrates such a development. He articulates fairly well and uses rather long sentences. His comments are usually built around some personal incident or some object in the immediate situation. When Daniel is asked to indicate the meaning of some word he has used, he is unable to do so. All that a word seems to do is to elicit a response that has been learned and associated with it. He apparently has no grasp of its meaning. He also fails when it is necessary to comprehend simple questions. He has learned to repeat words in a parrotlike way, but he can do little in using them intelligently. In truth, his acquisition and use of words are comparable to the learning of the defective, who gets the repetitive learning but can do little with his material in new situations. Daniel's intelligence quotient falls into the feeble-minded grouping.

Another phase of development often recognized in a young child is that in which his information is much in advance of his ability to reason independently. This is often seen in an only child or one who has been under the tutorship of an adult a great deal. Such a child may know colors and coins, may have a number concept beyond his years, and may use pencil and paper with ease. In fact, he is much at home with things that may be learned by individual help and attention. It is when such a child is faced with a problem which draws upon his own initiative and ability to reason independently that he fails. His whole attitude is one of waiting to be shown rather than of puzzling the problem out for himself. While the ability to learn readily from others is a measurement of intelligence, it does not constitute the sum total of intelligence. Neither does much learning make one particularly intelligent. It is not so much the amount that the individual learns as his ability to use what he has learned that is essential. It is in this respect that the overambitious parent is often deceived. The mother, in her zeal to hasten the mental development of her child, sets about teaching him all he is capable of acquiring, often to the disadvantage of the child. When the latter has reached the saturation point, he gives the impression of being overstimulated and confused and of possessing knowledge much in advance of his years but having little meaning to him. He has learned facts, but his intellectual immaturity does not allow him to use them well. This is the type of child who may have a very high intelligence quotient at an early age, but whose intelligence quotient drops perceptibly at some later examination. This child may experience difficulty in adjustment to his early school work, the reason often being that, through having much direction and supervision by a second person, he has built up such dependence that he is inadequate when this support is withdrawn and he is obliged to fit into the methods of teaching by group instruction.

A similar mistake is often made with the dull, slow child and the feeble-minded. Refusing to accept consciously the fact of the child's mental inadequacy, the parent attempts to compensate for his deficiency by forcing the rote learning. But the learning is not assimilated, and this becomes very evident when the child is called upon to apply it in some simple reasoning problem. Instead of finding it aptly applied, one gets a regurgitation of incidents and facts, a talking about something, as it were, without any proper relation to what the child is saying. In other words, he talks all around a question without in the end answering it. This type of child, too, is well known to the clinical psychologist and often has accompanying behavior problems.

Within recent years considerable study has been made of the so-called verbal, abstract, ideational type of child as compared with the practical, concrete type. While little is known psychologically concerning these differences, it is well recognized that such a difference exists. One child has no difficulty in mastering the symbols required for academic progress and has no trouble in reasoning out a situation not in the immediate present. In contrast to this child is the one for whom all forms of symbolic education are acquired with effort or are not acquired at all. In the immediate situation and in working with concrete material he is intelligent, but he fails miserably in his attempts to meet academic requirements. In other words, he has a type of intelligence which may adjust well in a program that calls for the practical everyday duties of life, but will be very much out of step in a bookish, academic environment. Again, this type may be recognized at a very early age and profitable advice given with reference to educational plans, if the parent will accept it. Too often this is not what happens. The plans and ambitions of the parents for the child will not allow this. They tutor, they drill, they nag, and they force, and all their efforts have only a very detrimental effect upon the child.

One cannot hope to portray all the types seen in a clinical service, and it is not the purpose of this writing to do so. Rather, the aim has been simply to indicate the nature and variety of problems that a clinical psychologist may meet and to emphasize the importance of adequate training and experience. This work requires the ability not only to administer the tests but also to interpret the results and to recognize the various phases of development with their possible relation to the problem for which the child is seeking clinical help.

THE SOCIAL WORKER

The social work in the habit clinic is complex and varied. All types of problems are referred from many different sources. The visiting nurse who finds a physically well child refusing to eat; a family-welfare worker who sees a mother so overwhelmed with the difficult behavior of one child that her agency's help is of little value to the family; the social worker from a child-welfare agency who seeks help for a child with the problems of defective speech or continued bed-wetting; parents worried and harassed by the ordinary, everyday problems of life as they are related to the child—all turn to the clinic for assistance. Many of the children come to the clinic directly

from a nursery school or a kindergarten. In these groups the teachers often note the child who finds difficulty in making adjustment to other children, who is obviously the victim of unwise training; and they will guide the mother to the clinic. Probably the most satisfactory referral is the one made directly by the mother who realizes that her child has a problem with which she needs help, for cooperation is then assured.

It is the social worker in her role as clinic manager who makes the important first contact with individuals or agencies wishing clinic help. She selects the cases which the clinic is best equipped to handle, makes the appointments for attendance, and when the mother and child arrive steers them through the routine clinical examinations and interviews.

The social worker is a member of the team consisting of psychiatrist, psychologist, and social worker, which makes a threefold study of the child. She investigates and studies the environment in which he is living, including the home and the neighborhood, and especially that most important part of the child's environment, the adults with whom he comes in contact. She learns from the parents, the teacher, and the nurse what has been observed of the child's personality, his reactions to punishment, his choice of playmates, his affections, moods, impulses—whatever will help to make up a picture of the child as he really is. She is, moreover, in a position to obtain much valuable information through visiting and observing the child informally in the nursery, the nursery school, the school, the home, the settlement house, the playground, or the community center. For in this way the child may be observed at his play or occupation, quite at ease and unperturbed, free from the fear and anxiety that are frequently associated with the more formal clinic contacts.

To this cross section the social worker adds a longitudinal view—she learns something about the family stock from which the child comes, the conditions under which he was born and reared, his development, the accidents and sicknesses he has had, and his reactions to them—everything that will help to explain the child to the psychiatrist when he comes to the clinic.

When the child has been studied at the clinic and a plan of treatment has been made, the social worker assists in carrying it out. The direct treatment of the child is carried on by the psychiatrist. However, the success of the program for the child of habit-clinic age depends largely on the cooperation of the grown-ups responsible for his training. The father's and the mother's attitude toward masturbation, the method of handling a temper tantrum, the teacher's persistence in correcting a speech defect, may all have to be changed if the child is to be helped. It is often necessary for the social worker to explain to parents again and again the clinic findings, to show them the important role each step plays in carrying out the plan of treatment satisfactorily. Reassurance and encouragement are often necessary, since the task of supplanting poor habits with good ones may prove a long and tedious process.

Frequently the plan for the child's treatment involves some service which the clinic is not prepared to give. For this reason the social worker must be familiar with all possible resources in her community and must know the type of case that each organization can best serve.

A more complete physical examination may be necessary. Deafness, for example, may cause temper tantrums or give an appearance of general retardation and must be ruled out before any plan can be made by the clinic. Enuresis (incontinence of urine) cannot be considered a habit problem unless no physical basis for it can be found. Intensive neurological studies and an intensive investigation of the endocrine glands may be essential. Only those most experienced in these particular fields of medicine can be of real help to the child.

Camps or schools give a temporary change of environment which is very helpful in determining the effect such a change makes in the child's problem. Even with a group of children of the pre-school age, the only possible solution sometimes seems to be long-time placement in a foster home. In such an event the child-placing agency gives invaluable assistance. If, as often happens, the mother is so preoccupied with some worry, financial or other, that she fails to recognize the necessity of help for her child or if her own worry is adding to the child's difficulties, the cooperation of a family agency that can work out a budget and give supplementary relief or steer the mother to a relief-giving organization is the first step in treatment. The social worker must know the clinic or agency that can best help the child, considering his age, his problem, and the family finances.

Although the most important part of her work is the service to the child who comes to the clinic, the social worker in the habit clinic has other duties, among which the supervision of students who may come to the clinic for practical training is important. The students will acquaint themselves with the clinic methods by the study of records and through staff conferences at which the psychiatrist, the psychologist, and the social worker present their parts of the investigation and treatment. Study of the contacts other agencies have had with new clinic cases gives the students the opportunity to learn of the community resources at first hand. Follow-up visits test out their ability to make satisfactory interviews and personal contacts. Finally, a few cases are turned over to the students, always under careful supervision.

The material which is gradually collected in the form of records is particularly valuable for research purposes, as it deals with young children whose problems may be projected into the future and who as a group lend themselves to follow-up studies and research. The collecting and analyzing of such data as may be obtained should be useful in showing various trends and in evaluating results of treatment at the clinic when compared with carefully controlled untreated problems of a similar nature.

The amount of educational work which the habit-clinic social worker can do seems to be limited only by the time which she can give to it. That the child's early years are important in his future adjustment to life's problems is still not widely appreciated. Talks to mothers' clubs, to groups of teachers, and to others interested in child training, on the importance of mental health and the value of the services of a child-guidance clinic, especially to preschool children, are time-consuming but unquestionably another important part of the job.

With so broad a scope of activities it is most important that the social worker not only fulfill the usual requirements of education, training, and experience but also have a sufficient reserve of strength and energy to enable her to meet numerous and varied demands with skill and resourcefulness, to be ready to tackle a new situation with initiative, and to be able to see the old problems with a fresh point of view.

HABIT-CLINIC PROCEDURE

Parental education may be said to be the backbone of habit-clinic procedure, supplemented by a direct psychiatric approach to the mental health of the child in an attempt to understand his particular difficulties in making the necessary adjustments to life. The sources of habit-clinic cases are varied. Social agencies, nursery schools, kindergartens, private physicians, hospitals, nurses, and parents all refer cases for study. As education in mental hygiene has become more general and parents have become more concerned over evidences of maladjustment or inadequacy in their children, and more enlightened concerning the environmental factors affecting conduct, an increasing number of cases have been referred by the parents themselves. Whether the child is referred by a nurse, a teacher, a social worker, or the parents, the procedure is the same.

A visiting nurse entering the home of Mrs. S found the mother very much upset, nervous, and agitated on account of having been worried all day by her little daughter Mary, aged 2 years 2 months. Casual inquiry at this time revealed the following facts: The child was extremely disobedient, almost to the point of being negativistic. She absolutely refused to respond to a direct command and could be managed only by constant coaxing. Although Mary had been weaned months before, the mother had resorted to the use of the bottle in order to comfort her before her nap and before her bedtime, and as a help in getting sufficient nourishment into the child to keep her from losing weight. At every meal the mother was put through the typical ordeal of feeding the child herself, often being rewarded for her efforts by having the child spit the food out on the floor. It was also mentioned quite incidentally that the child wet the bed every night and had done so ever since the mother had resorted to bottle feeding.

With this information at hand, the nurse reported the situation to the supervisor in charge of the settlement house where a clinic was being held, having first interested the mother in the habit clinic and what it is trying to do for this type of case. The supervisor then referred the family to the social worker of the habit clinic, who within the next 2 or 3 days made a careful social investigation of the home. The following is a brief summary of her report:

SUMMARY OF SOCIAL WORKER'S REPORT

Case of MARY SMITH

The family live in a very poor and crowded district. The street is narrow, unpaved, and cluttered with papers like an alley. There are three-story brick tenement houses on each side, and one has the feeling that it is a congested neighborhood, as the street is crowded with children, there is a great deal of noise, and many people are hanging out of the windows.

The patient's family, consisting of father and mother, Mary, and a little girl of 6 months, occupy a four-room tenement with bath, on the third floor, for which they pay \$20 a month. The house is very clean and is neatly and prosperously furnished. It has a living room, a dining room, a kitchen,

and a bedroom. All members of family sleep in one room. The patient has a crib by herself.

The mother is a slight, delicate young woman of 20, who enjoys house-keeping and is very much interested in her home. She went 2 years to high school, then worked as a clerk before marriage, and has been married 3½ years. She has a bad temper and is easily excited. She told the worker that when the patient does not mind her immediately she becomes impatient and "feels all stirred up inside."

The father is a short, well-built man of 24, who drives a garbage truck for the city, earning \$24 a week. He is in good health, is interested in his home, and plays with his children. He and his wife differ in regard to discipline, he often telling the child that she can do things which her mother has forbidden.

The patient was born full term, instrumental; one eye was black and blue. Development was quicker than that of the average child. First tooth: Four months. Walking and talking: Under a year. The patient has had no diseases or convulsions. The only evidence of illness is that 3 weeks ago she had a fever of 103 and was nauseated.

Habits.—Sleeps from 6:30 p. m. to 6 a. m. Is restless and occasionally cries out for mother in her dreams, awakens, but goes back to sleep again. No night terrors. Has a 2-hour nap in daytime.

Feeding.—She is not finicky but has a capricious appetite. At different times refuses different foods. Always has to be coaxed and occasionally spits out her food. Will not drink milk except from a bottle. Is always given one when put to bed.

Enuresis.—Wets bed every night.

Disposition.—Affectionate; demonstrative; generous; not jealous, pugnacious, nor domineering; very stubborn and inclined to be negativistic. Always has to be coaxed to do things; is very disobedient.

Play life.—Enjoys playing with other children but can amuse herself if left alone. Likes dolls.

Summary.—There is no evidence of nervous or mental disease in the family. The chief problems are refusal of food, enuresis, and disobedience. The mother is excitable and easily loses patience with the child. The father seems sensible, but the parents disagree in regard to discipline.

The mother was asked to report with the child at the clinic the following week, at which time the child was immediately taken in charge by the psychologist, whose report is here summarized.

SUMMARY OF PSYCHOLOGIST'S REPORT

Some 15 or 20 minutes before the psychological examination was begun, friendly relations were established. The child, after an initial hesitancy and shyness, quickly became interested in playing and enjoyed especially the drawings of a cat with long whiskers. As she is of that age where best examination results are obtained with the mother present, provided she uses discretion, the mother was given the usual instructions as to how she could help in the examination. The mother was quite interested, and excellent cooperation was secured. She smiled encouragement from time to time and did not let Mary know when a failure had occurred. She wisely refrained from distracting her by urging her to do better.

Mary showed but slight hesitancy about entering the examination room. As soon as she saw the pictures and the colors her self-consciousness disappeared. The tests given her were presented as games and she quickly caught the play spirit and very willingly tried to do everything that was asked of her. The mother, too, was pleased and incidentally quite surprised that the youngster did things which she had never tried before.

Mary is 2 years and 2 months old. She developed rather more quickly than the average child. Her first two teeth came in at 4 months. She said such things as "mama" and "papa" at 6 months and a large number of words plainly at 9 months.

As far as formal tests are concerned, this child made a very good showing. With one exception she did satisfactorily all tests that the average child of 2 does. Pictures took her eye, and she interestedly pointed to objects in the pictures and named one or two in each. She quickly imitated such movements

as raising arms and clapping hands and quickly carried out simple requests such as "Bring me that ball," "Now throw it to me," and "Go over there and sit on that chair." Before eating a piece of candy, she removed the paper in which it had been wrapped. Her one failure in the 2-year test was that of copying a circle with a pencil. As her mother has never allowed her to use a pencil lest she mark up the house, this failure is insignificant. She passed four of the 3-year tests. She knew her full name and her sex and she took delight in pointing out her eyes, nose, mouth, and hair. She pointed to shoes, stockings, and dress, and was familiar with the names of common objects, such as penny, a knife, a key, a watch, and a pencil. In all informational questions she did exceptionally well.

Summing up results, we find that Mary has a mental age of 2 years and 6 months, as against an actual age of 2 years and 2 months, which gives her an intelligence quotient of 116. Her developmental history, her general alertness and interest in things about her, her quickness in learning, and her rating on formal tests show a child above the average in intellectual equipment.

INTERVIEW WITH PSYCHIATRIST

Shortly afterwards the mother was interviewed by the psychiatrist, and although the following conversation was not taken verbatim, it represents what was said as nearly as can be remembered from the notes dictated a few hours later:

DOCTOR. I understand from Miss W, who visited you the other day, that Mary is becoming quite a problem.

Mrs. S. She is, indeed. I hardly know what to do with her. She refuses to eat anything, and she gets me so worked up and so tense inside that I go into hysterics.

DOCTOR. Then perhaps you are not feeling very well yourself.

Mrs. S. I am feeling all right now, but at times I get nervous.

DOCTOR. Under what conditions are you most apt to get worked up, Mrs. S?

Mrs. S. Usually when I have had arguments with my husband regarding Mary—how to make her mind and what I should do. When I am trying to make her mind or take her food, he butts in and says, "Let her alone. Don't keep bothering the child." And on other occasions when she is doing things that he doesn't like, he asks me why I don't make her mind.

DOCTOR. One may assume from the report which Miss W brought to me that you and your husband get along very well, that you are both fond of and very much interested in Mary, and that you want to do everything possible to have her overcome these undesirable habits.

Mrs. S. Yes, sir. Mary's behavior is the only thing over which we have any arguments at all, and we both want to do all we can to help her.

DOCTOR. You know, Mrs. S, that a child of Mary's age, especially a child of Mary's intelligence, has a very much better understanding of the ordinary things going on about the household than you give her credit for. It is surprising how early a child learns that there is some doubt in the minds of her parents about just what is right and what is wrong, and, quite naturally, when there is any doubt in the child's mind about what course he is to follow, he is very apt to take the easiest one. So it is extremely important that you and Mr. S have a definite understanding about what you are to expect of Mary. You know, too, that not infrequently parents are apt to discipline children in a rather erratic way. By that I mean that much depends upon how the parent happens to be feeling at the time the child needs discipline. If the mother is in a cheerful state of mind and not tired out by the household duties, some breach of discipline may be looked upon as quite amusing, the parents may speak of it as "cute," and the mother may laugh at the child instead of reprimanding her. On the other hand, if the same thing happens at the end of a hard day when the mother is worried and annoyed and somewhat out of temper herself, the child may be punished, sometimes severely and out of all proportion to what she deserves. Of course, you understand that I don't mean that is the method used in your home, but it is a method used in most homes more or less. I just mention it so that you will understand better what I mean by the importance of getting together with your husband and talking these matters over.

Mrs. S. Yes; I know lots of mothers who do just that—laugh at the baby as “smart” one day and slap him for the same thing the next.

DOCTOR. I would also call your attention at this time to something that you probably know already, and that is, that it is very bad to have the parents question each other's methods of discipline before the child. It is much better to have the mother or father carry out his or her own method, even if the other parent is not in full agreement with what is being said or done, and then discuss the whole thing in private after the child has gone to bed. It is only in this way that the child learns that the parents are united in their efforts to bring about the desired manners and habits. I think it is of the greatest importance that you talk these things over with your husband and have an agreement that will prevent any discussion of authority before the child.

Mrs. S. Yes, sir; I see exactly what you mean.

DOCTOR. Now we will discuss the feeding problem. I understand that Mary has not as yet given up the bottle.

Mrs. S. I had her weaned from the bottle, but she absolutely refuses to take milk from the cup. It was only when I put a little water with it that I could get her to drink it. I took her to the doctor, and he said if she wouldn't take milk from the cup, to let her have it from the bottle, and that is what I have been doing the last few months. She gets the bottle every morning at 10 o'clock when she takes her nap and every night when she goes to bed.

DOCTOR. Of course, you appreciate the fact that Mary is old enough to give up this bottle and that her clinging to these habits so strongly simply represents a desire on her part to stick to those infantile methods which she should be gradually giving up. The feeding problem, and the bed-wetting as well, represent habits that are quite normal for infants but that she should have outgrown some months ago, and it is going to be a great deal easier to break her of these habits at 2 years of age than it will be at 4 or 5. There is no better time to begin than the present.

Mrs. S. I realize all that and am willing to do whatever you say.

DOCTOR. Tell me a little about other difficulties with her feeding.

Mrs. S. She absolutely refuses to take any food unless I feed her.

DOCTOR. You mean that you have to sit down beside her at each meal and actually take the food from her plate and put it into her mouth?

Mrs. S. Yes; and she even spits it out.

DOCTOR. Then mealtime must be a very trying experience for you.

Mrs. S. Yes; it is the worst time I have.

DOCTOR. Then let me tell you what I have learned from my experience regarding children who cause so much difficulty by refusing food. In the first place, we must remember that it is a very natural thing for all human beings to crave attention, and this is particularly true of children. The refusal of food is frequently a method that children use to get the time and attention of the parents. At that time they become the center of attention, and it is a battle of wits between the mother and child to see which one will win. The mother frequently puts the food on the table with serious doubts and misgivings in her own mind as to whether the child will eat it, and perhaps her first remark is, “You have got to eat this. You are not going to get up from the table until you do eat it. You didn't eat any breakfast and you cannot go out to play until you have eaten your lunch.” This immediately puts the child in a rather defiant mood. Even if it had not occurred to the child to refuse his food, this in itself acts as a challenge. It is just as though there were a little play going on, in which the child is taking the leading part—a situation in which both children and adults like to find themselves. We know that the child knows that invariably, if he does not eat his meals at the regular time, the anxiety of the mother will make her only too willing to provide food between meal hours. So in this way the child is not only able to defy the parent and attract attention and win his battle, but he is also able to get the amount of food which his system requires. It may be that he doesn't get the best type of food and the kind best suited to nourish him, but he gets the food which pleases him most and satisfies his hunger, and that is about all the child wants.

Mrs. S. But, Doctor, if I let her go without her meals she will get so thin.

DOCTOR. It will be hard at first, I know, but I would suggest that from now on, or at least during the next week, you and your husband agree to the following plan: Place on the table a smaller amount of food than you would naturally want the child to eat. This should include milk, cereal, fruit, and whatever else you may wish her to have, and absolutely nothing should be said

regarding the food itself or the child's eating it. If the child is eating with you and your husband, pay no attention whatever to her eating. After you have finished and sufficient time has been given the child to eat her food, remove the dishes and say nothing at all regarding the amount of food the child has eaten. If Mary has not been in the habit of having milk between meals, under no circumstances give it to her.

Mrs. S. She has been having the bottle at 10 o'clock, just before she takes her nap.

DOCTOR. Then, under those conditions, I should give her an equal amount of milk in a cup. On the way home, I should drop into the drug store and get some straws and let her use those during the coming week. It will be a step away from the bottle and will interest her in taking the milk from the cup.

But to continue regarding the more general statements as to her feeding habits: Do not be concerned if she does not eat much for the first few days. It will take a day or so for her to learn from your apparent lack of interest in her eating that no one is very much concerned whether she eats or not. In other words, try to get away from romance at her feeding periods. Mary will soon find that she no longer occupies the center of the stage during the meal hour. I appreciate that you will be just as concerned, but the important thing is not to let Mary know it. The task I have outlined is a difficult one, I know, but it is not nearly so difficult to manage now as it is going to be a year or two from now; and although the results may be discouraging at first, you may be assured that in the end it will work out not only to Mary's advantage but to your own.

Mrs. S. Well, I'll try this week and see if I can stand it.

DOCTOR. I don't want you to look for improvement today or tomorrow or the next day, but I want you to think ahead 3 or 4 months and then picture Mary eating in a perfectly normal, healthy way without causing you or the rest of the family any disturbance. The only way to do this successfully, that I know of, is to follow the plan that I have just outlined.

It is absolutely essential that you and Mr. S work together on this matter, because if you do not cooperate the whole plan is doomed to failure, and this first victory for Mary may work out to her disadvantage in later life. I am sure you know many people your own age who are terribly finicky about what they eat, having all sorts of digestive upsets, refusing to accept any suggestion made by others—the type of person who is generally disliked and hard to get along with. It is just such people that children with all sorts of finicky habits are quite likely to develop into.

Mrs. S. I certainly wouldn't like Mary to grow up like an old woman who lives near us. She's just like that, and nobody can stand her.

DOCTOR. Do you think you will be able to carry out the plan I have outlined? I mean by that, do you feel that you will have the courage to let Mary go for a few days without what you feel is a sufficient amount of food in order to make her appreciate the fact that whether she eats or not is a thing which primarily concerns herself, and that going without food is not going to develop a tremendous upset in the home?

Mrs. S. I think I see what you mean, and I surely will make every effort to carry out your instructions and get my husband to also.

DOCTOR. Now, let us consider the problem of enuresis. I understand that Mary wets the bed practically every night.

Mrs. S. Yes, Doctor; every night. It has been much worse since she has been getting the bottle just before she goes to sleep.

DOCTOR. Now, since the time is getting short I want to outline a plan for that with less explanation than for the feeding problem, as I think this is a much more mechanical thing and will respond to treatment more easily.

Mrs. S. I have whipped and whipped her, and as it does no good I have given it up as useless.

DOCTOR. You were wise in giving up whipping her for this habit because she is undoubtedly in no way to blame for it, and it is quite an injustice to whip children for things over which they have no control.

Mrs. S. I agree with that.

DOCTOR. Now, at what time does Mary usually go to bed?

Mrs. S. At 6:30.

DOCTOR. And at what time does she have supper?

Mrs. S. At 4.

DOCTOR. Then I would suggest that you follow out in detail this plan. Let Mary have her supper at 4 o'clock, with such liquids as she is in the habit of taking, bearing in mind that she is to take the milk from the cup and not the bottle. Between 4 and 6:30 she is to have no fluids whatever. Before going to bed she is to be taken to the toilet, and you must see that she passes her urine. When she is put to bed make her understand that she is to be taken up later on in order to prevent her from wetting the bed. What time do you go to bed yourself, Mrs. S?

Mrs. S. At 12 o'clock.

DOCTOR. Do you mean that you go to bed every night at 12 o'clock?

Mrs. S. Yes.

DOCTOR. Isn't that rather late?

Mrs. S. Well, after supper my husband listens to the radio until about 10:30. Then I make tea, and we have a little lunch, and by the time I get the dishes cleared away it is about 12.

DOCTOR. Then I would suggest that you make a tour of inspection every hour in order to determine at just what time Mary wets the bed, and that at 10 o'clock, 3½ hours after she has gone to bed, you get her up, thoroughly awaken her, and take her to the toilet. Make sure that she realizes why she has been awakened; that is, that it is in order to prevent her from wetting the bed. It is important that you do not pick Mary up in a semidrowsy state and simply place her on the toilet; she must be awakened thoroughly and given to understand exactly why you have awakened her. Then you can put her back to bed and allow her to remain until you get up in the morning, which I presume is about 6 o'clock.

Mrs. S. Yes, sir.

DOCTOR. I am sure that if you follow out the instructions I have outlined regarding the feeding and bed-wetting, you will be able to report considerable improvement when you return next week.

Mrs. S. I hope so, for it makes me so much extra work to have her go on this way.

DOCTOR. Before you go, I want to remind you again of the most important and fundamental thing that I have said this morning, and that is that you and your husband discuss this matter of discipline openly and frankly and decide upon a plan that will insure cooperation. It seems only natural, inasmuch as you see more of the child than your husband does, that the discipline should be in your hands and that he should support you and help you follow out the plan that you agree upon. Under no condition allow Mary to feel that there is any disagreement between you two as to what is best for her to do. As soon as she finds out that the household is divided against itself the battle, so far as you and your husband are concerned, is lost, and a great injustice is done to Mary.

I see by the tests that have been worked out this morning that Mary is a keen, bright little girl of unusual intellectual equipment, which means that she will be all the more capable of taking advantage of any failures which you and your husband make.

You may be assured we will do everything possible to help you during the next few weeks, and there is every reason to believe that by Christmas time Mary's difficulties will be well overcome. Can you arrange to come back a week from today?

Mrs. S. Yes.

DOCTOR. Then that will be all this morning. But the problem of correcting her undesirable habits will have to be solved very largely by you rather than by Mary. I should like to get just a bit acquainted with Mary before you go.

The mother brought the child into the examining room, but no effort was made on the first visit other than to make friendly contact with her. She appeared to be a bright, keen little girl, well developed and fairly well nourished. She seemed interested in everything in her environment. In running about she fell down and knocked against a chair hard enough to hurt herself considerably. She immediately began to cry, but it was not difficult to attract her attention to something else, and the tears did not last long. Her attitude in the clinic during the short period of observation revealed

nothing that had not been brought out by the reports of the social worker and the psychologist.

Had this child been a year older, with her rather superior intelligence, an attempt would have been made to interest her in keeping a record of her success regarding both feeding habits and enuresis. She would have been given a chart such as the accompanying one, and every effort would have been made to arouse her interest in obtaining as many stars as possible on her chart, which she would bring to the clinic the following week. Not only can the chart system be made a matter of great interest to the child, but it also serves as a detailed record of what has been done during the clinic intervals. That is, instead of having the parents report that the child has done pretty well or poorly regarding such problems as feeding, enuresis, and temper tantrums, we have a very definite quantitative record of exactly what success has been attained.

The chart system has been criticized by some as savoring of bribery, but there is no reason why the child should be denied some visible evidence of approbation of his efforts. Neither is there any reason why such efforts should not be rewarded if conditions permit. The incentive for most efforts, in either children or adults, usually resolves itself into a striving for approbation or reward and it is rather unreasonable to deny children the same approbation that most adults are seeking.

The following chart shows how the record is kept :

NAME: *Sally Jones*

OCT 5 to OCT. 12.

EVERY STAR MEANS SUCCESS IN EATING MY MEALS.

	<i>Breakfast</i>	<i>Dinner</i>	<i>Supper</i>
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

However, it was not feasible to utilize the charts for Mary, as they were beyond the comprehension of a child 2 years old; but if the parents, who were keenly interested and who had at least average intelligence, cooperated, there was every reason to believe that the child's problem would not be particularly difficult to solve.

An effort has been made in the foregoing paragraphs to give the reader a fairly good idea of exactly what takes place during the first visit in the case of every child coming to the habit clinic. Whether the problem is one of enuresis, feeding, or masturbation, or whether it is one of the more difficult personality defects—such as jealousy, shyness, cruelty, or abnormal fears—extreme tact and diplomacy are needed, in order, on the one hand, not to offend the parents, and, on the other hand, to impress them with the importance of the mental side of the child's life. They invariably feel that they have used all the patience and good judgment that might be expected of any one handling the problem with which they are confronted. Thus it is necessary to generalize and speak in a more abstract way

on the first visit than is necessary after working relations have been established and the parents have developed confidence in the clinic. It is essential in conversing with parents to explain the points made by examples that are well within their comprehension. Care must be exercised not to criticize harshly or unjustly, and it must always be borne in mind that the interest of physicians is primarily therapy and not science or morals.

COOPERATION WITH OTHER COMMUNITY AGENCIES

It must be kept in mind that if children as a group are to benefit by the available knowledge regarding mental health, every resource of the community must be utilized to its fullest extent. It is of paramount importance that every organization interested in the welfare of children should make a careful survey of what other organizations with similar interests are doing and of which activities have been most successful. The value of the resources which such agencies have for supplementing the work carried on by a child-guidance clinic cannot be overemphasized.

The available facilities which can operate independently or in cooperation with the clinic vary according to the size of the community and the interest and progress that have been shown in the field of child guidance. In urban communities there are usually many organizations which are directly or indirectly concerned with some aspects of this problem. Some social agencies providing service for children or families are equipped to do child-guidance work and others have psychiatric social workers on the staff able to give the treatment indicated by the study of the child made by a child-guidance clinic. Public agencies such as the schools or the juvenile court also may be equipped to provide child-guidance service to some of the children needing such service. In addition, there are usually a great variety of agencies that can assist the clinics. Any well-organized clinic should use all the facilities in the neighborhood that are of value in the treatment of the problem and that would help the future development of the child.

In the treatment of preschool children health centers and nursery schools and kindergartens can render significant service to the child. These important centers of training should be recognized by child-guidance clinics for their educational value in helping parents to understand that a child's emotional life is as important as his intellectual equipment and his physical endowment. These centers should also assume the responsibility of studying behavior problems in order to treat the child with wisdom at a time when wise treatment means so much to all concerned.

The public-health nurse, for example, is in a most strategic position not only to recognize undesirable habits and personality traits, but in many instances to institute simple methods which will correct these tendencies before they become firmly fixed as a part of the child's personality. Every nurse should have some training in mental hygiene. This is particularly true of those engaged in community health work. Many of the simpler problems of eating, sleeping, and toilet habits are matters of training which the nurse should manage efficiently.

Teachers in nursery schools and kindergartens should look upon the development of personality as an educational problem. They, too, are in a unique situation and should render valuable service to the parents and the public by detecting deviations from normal conduct, whether it is in rate of achievement in school work or whether it has to do with the child's ability to get along with his playmates. They usually enjoy a friendly and cooperative relationship with the parents of children under their charge and are often in a position to know intimately the home conditions under which the child is being reared. Herein lies the opportunity for much valuable work in the field of parent education.

Older children and some preschool children may need service from other types of organizations. Important among these are case-work agencies which provide service to children in their own homes and assist parents to understand their needs, such as family agencies, children's agencies, and visiting teachers in the schools. Some of these agencies provide the financial assistance that is essential to the dependent family. Others place the child in an environment best suited to his need, whether this is a foster home, a special institution or hospital, a nursery school, or a vacation camp. Clinics and hospitals carry out the examinations and treatments that are essential to health as well as the follow-up service for the child who is in need of medical care. Other agencies giving service to children are those providing organized activities for boys and girls or opportunities for recreation such as Boy and Girl Scout or Campfire groups, Big Brother or Big Sister Associations, organizations for young men or young women, recreational centers, organized playgrounds, settlements, and churches. Some children may need the special service of the school for social counseling, school placement, or vocational guidance.

The work of a child-guidance clinic should be that of a community center. Only by intelligent pooling of all community service can we be sure that the child is receiving all the advantages which the community has to offer.

THE CHILD AND HIS PERSONALITY

Almost every discussion of the child and his personality carries with it a long dissertation on heredity which is likely to leave one either in a state of increased perplexity or with some very dogmatic ideas, depending on the author. Some writers maintain a consistently noncommittal attitude, and others state their views for or against the importance of heredity with great conviction. Thus, for example, John Stuart Mill made the statement, "Of all the vulgar modes of escaping from the consideration of the effects of social and moral influences on the human mind, the most vulgar is that of attributing diversities of conduct and character to inherent natural differences"; whereas Frederick Adams stated just as emphatically that in his opinion both "experimentally and statistically, there is not a grain of proof that ordinary environment can alter the salient mental and moral traits in any measurable degree from what they were predetermined to be through innate influences."

The consensus of opinion of physicians dealing with the practical problems connected with the subject of heredity is well expressed by Kirkpatrick in the following paragraph:

From the individual standpoint, heredity should neither be ignored as of no importance nor yielded to as inevitably fixing one's destiny. Instinctive and hereditary tendencies are the roots from which the physical, mental, and moral life develops. Some individuals develop more readily and to a greater degree than others. All are of the same human characteristics, but each may make the most of his environment. Some cannot go as far as others in certain directions nor as easily, but no one has exhausted his possibilities of development. The practical problem is to expend our efforts upon the useful characteristics which we possess in the greatest degrees.¹

It seems only reasonable at this time when so much disparity exists in the opinions of various writers on heredity that a conservative point of view, such as that presented by Kirkpatrick, should be tentatively accepted. Such a hypothesis makes it possible to get away from the pessimistic attitude to which the fatalist clings with undying tenacity. Doing this is not seeking a fool's paradise and becoming oblivious to the biological facts of life. Whatever may be the relation between the germ plasm and the color of eyes or the size of foot, and whatever research may determine in regard to defective germ plasm—how it affects the number, size, and distribution of brain cells, evidently resulting in variations in inherent mental equipment and setting definite limitations on brain development—no one, as yet, is ready to say that personality and all its component parts are not molded and colored by social heritage to a great degree. After all, social maladjustments are more frequently due to emotional instability than to intellectual defects. More is to be gained by concentrating upon the study of environment and its effects on the de-

¹ Kirkpatrick, Edwin A.: *Fundamentals of Child Study*, p. 29. Macmillan Co., New York, 1917.

velopment of personality than by accepting a hopeless, fatalistic theory of heredity.

In the attempt to understand the child it must not be forgotten that just as he has ears, eyes, a brain, and a heart, so he has instincts and emotions. He has, for example, an instinctive fear of falling and is afraid of loud noises. He has an inherent hunger for self-expression that is constantly infringing upon a code of laws and customs of which he has, as yet, no understanding. We must remember that the child has plans, hopes, and ambitions; he has doubts, fears, and misgivings; he has joys and sorrows, some very slight and fanciful, others very deep and real. This emotional life is thwarted and gratified in much the same way at the age of 3 that it is going to be at 30.

With all these instinctive and emotional drives, which have much in common with those of the adult, there is necessarily lacking the stabilizing factor of experience which can come only with years. The child is confronted with many new situations to which there is a definitely unpleasant emotional tone. For example, many of the primary experiences of children with animals are accompanied by fear. Jealousy is often aroused when the child first appreciates that the mother is giving some of her attention to other members of the family. Anger is aroused repeatedly until the child appreciates the reason for the acts which give rise to these emotions, and then suddenly and unexpectedly the emotional reaction changes. The child, therefore, must be considered as an individual with all the equipment necessary for registering joy and sorrow, pleasure and pain, but with little experience for properly evaluating the details of the situation so that the quantity and quality of the emotion will be adequately expressed. Regrettable as it may be, adults all too frequently stimulate some of the child's most undesirable emotional reactions for their own amusement, leaving permanent scars on his personality.

Childhood is not only the opportune time but the only time to initiate a program of mental health. Seeds of pugnacity, selfishness, and feelings of inferiority are sown early. They may not bear fruit until later—perhaps never; but if one expects to develop an adequate, well-rounded, self-sufficient personality, one must plant the seeds for it during the child's earliest years and carefully nurture them. The mental life of the child is characterized by his tendency to imitate, his suggestibility, his love of approbation, and his marked plasticity. These qualities, in association with his lack of experience, training, and education, render an interpretation of his mental activity less difficult at this time than in later years. All these factors may be utilized to great advantage in our efforts to stimulate, inhibit, or alter his reactions to the problems of everyday life. In the effort to understand human behavior the thoughts and feelings of the child must be taken into account. His daydreams become matters of importance. More intimate knowledge of his mental life is needed. It is necessary to take time to find out why he is queer, quiet, or reserved, why he is worried or sad. The situation demands the utmost ingenuity and patience in assisting the child to solve his own problems and at the same time appreciation of the fact that it would be of little value to solve them for him.

The infant at birth has no habits, and the habitual reactions which he acquires in the process of growing up are dependent upon his experience, training, and education. He seems, however, to have certain inherent tendencies which manifest themselves at an early age. Thus one child reaches out and embraces the world in a happy manner and another withdraws and rejects all attention. Such tendencies seem to be present at birth. Yet these so-called instinctive reactions are all modified, either to the advantage or to the disadvantage of the individual, through the effect of environment. Habits represent the child's responses to the innumerable, ordinary, everyday-life situations. Knowledge of an individual's habits makes possible a fairly accurate guess as to what may be expected of him in ordinary situations. As Doctor Dewey has pointed out, habits are not like a garment to be put on and taken off as the occasion demands, or as it pleases us. They are very much a part of us; we are the habit.

We begin to acquire habits at birth and continue to acquire them to a greater or less degree, depending upon our plasticity, until the end of life. The functions of eating, sleeping, and elimination become habitual. We develop habits of conduct toward those in authority. In some situations we acquiesce; in others we rebel. We have habits of conduct which include morals and manners. Our mental attitudes toward life are but habits of thought, and such traits as selfishness, shyness, cruelty, and fearfulness are merely emotional responses that have become habitual through repetition. Lying, stealing, and a disregard for the rights of others are likewise responses to certain situations, which through repetition become a part of the life pattern; in other words, they are habits.

It therefore becomes obvious that habits considered in their broadest sense are nothing more nor less than the individual himself, his happiness and efficiency being largely dependent upon the habits which he acquires in the process of growing up.

Almost from the moment the child is born he is confronted with all the varied life situations evoking what we think of as adult emotional responses. The child does not advance very far in life before he knows what it is to be jealous, to be fearful, to be angry, to love, to hate, to feel inadequate, and to experience sorrow and disappointment. He is continually subjected to environmental situations and personalities which stimulate these varied responses and lay the foundation for mental attitudes which eventually become habitual.

The child is recognized as being amoral (without morals) at birth. His responses to life are those that are essential to the preservation of self. He reaches out for that which brings him pleasure, smiling upon those who cater to his appetites, provide him with food, drink, and creature comforts, and stimulate pleasant bodily sensations by fondling and kissing him; and he rejects things and people not serving his immediate needs. His demands for attention must be recognized; his attempts to exhibit an influence over his environment must not be thwarted or there will be evidence of resentment. He is, indeed, a self-centered, egotistical individual who feels no responsibility toward life except that of trying to satisfy his own needs. All that he acquires in the way of ideals, altruistic tendencies, cooperation with his environment, and desire to please must come from his experiences

with life, and during his early years these experiences are to a very large extent closely tied up with his parents.

It is therefore important that parents appreciate the raw material with which they have to deal, that they know something about these inherent strivings of children, their emotional stability, and their intellectual equipment. As time goes on parents should be intimately acquainted with the personality make-up of the immature individual whose future life is so dependent upon their interest and wisdom. They cannot afford through ignorance to twist and distort the personality make-up of the developing child through a domineering intolerance or humiliation, or by teasing, ridiculing, and cheating him, and destroying his sense of security. The child subjected to personalities that are egotistical, domineering, unstable, quick-tempered, and ill-mannered, has a right to become rebellious. It must be kept in mind that the child is not satisfied with being simply a passive part of his environment. He is persistently reaching out and struggling to make the environment satisfy his emotional needs. The parents' duty is to see that the emotional needs of the child are satisfied in a way that is compatible with the requirements of society.

In any effort to understand the behavior of children and to recognize the importance of the part environmental factors play in their conduct, it is essential to keep in mind the personality make-up of the individual child. No two children are subjected to the same environmental influences. The material situations may appear to be not very different, but the personalities of parents and others who are responsible for the training of the child vary widely, and these personalities are the most important aspect of the child's environment. To a very large extent the habits and the mental attitudes which become incorporated into the child's personality make-up are dependent upon the wisdom of the parents. They are the ones who must prepare children to live in a world outside the home. They must see to it that children are both ready and willing to make the necessary adjustments to life as it really exists. In this outside world the environment will not be altered to suit the child, as it frequently is in the home. Parents themselves must keep in mind, and must help the child to grasp the idea, that the individual and not the world makes most of the compromises and concessions when conflicts arise.

THE PARENT AND THE HOME

The home must be considered the workshop in which the personality of the child is being developed; and the personalities of the parents will make up, to a very large extent, the mental atmosphere in which the child has to live. This mental atmosphere may easily become contaminated and can be quite as dangerous to the mental life of the child as scarlet fever or diphtheria would be to his physical well-being. Faulty habits are not infrequently due to the imitation of bad examples. Yet one is quite safe in saying that the mere imitation of the bad example is not nearly so dangerous to the child's mental health as may be the way in which the indiscretion is treated by the parent. In any study of environment, therefore, it is absolutely essential to have the fullest details possible regarding the personalities of the individuals with whom the child comes into intimate contact.

Parents who are largely responsible for the inadequate development of their children's personalities may be divided into well-defined groups. There is first of all the mother who, although worn and wearied by her routine household duties, tries to supplement the family income by putting in several hours a day sewing, washing, baking, or scrubbing when she should be in bed. She has little energy, either physical or mental, to give to any consideration of the welfare of her children. In striking contrast to her is the work-avoiding, duty-shirking, pleasure-loving mother who feels that her duty is ended at the birth of the child and turns over her responsibilities to a nurse-maid. Again, there is the mother with excellent intentions, whose unintelligent interest is apt to defeat its very purpose. Usually she is oversolicitous and caters to every whim and desire of the child. All too frequently she is emotionally unstable and the child soon finds out that she has no definite rules and regulations about discipline. What is condoned today is punished tomorrow; and in spite of his ability to make rapid adjustments, the child finds it difficult or impossible to follow a consistent line of conduct. More pathetic than any of these situations, however, is that of the mentally defective mother who does the very best she can with her limited endowment and yet fails and recognizes her own failure.

So far only the mother has been considered but it must not be forgotten that the father's influence also must be considered. He may spread peace and harmony where chaos was wont to prevail, or he may disrupt and render chaotic that which was peaceful. The stern, righteous, rigid father who dominates the household by fear, is, from a mental point of view, perhaps the most undesirable. Yet there is no reason to envy the child who has a quick-tempered, impulsive father always ready with a sharp word and a blow. Lucky is the child who does not have his discipline handed out in an erratic manner by an emotionally unstable father.

Needless to say, the foregoing types fail to furnish the child with the very companionship which he needs most. Cheerfulness, affection, and kindly consideration; frankness and honesty in answering questions, so that speech and action may be free and uninhibited by fear of punishment or silent contempt; manners and speech that are not forbidding—all these tend to play a part that cannot be overestimated in the development of the child's personality.

To evaluate parental personalities requires more than a study of the personality make-up of isolated individuals; it entails a study of a complex relationship between two human beings endeavoring to carry out a very difficult task, usually without training or experience and sometimes without interest or desire. One need not be surprised that two such individuals do not always create a quiet, peaceful, happy home in which the child will find everything necessary for a healthy outlook upon life. Sometimes even an intelligent, well-educated man and woman with common interests will not make for efficiency when operating together as parents.

Much sentiment has rightly been lavished on the home—the place where the disheartened and the troubled find understanding and comfort, the fortress where those in need may find safety and security from a critical, demanding, competitive world. Unfortunately not all homes serve this ideal purpose. All too frequently the average person—man, woman, or child—makes less effort to keep up his morale in the home than in the shop, office, school, and place of recreation. Too frequently the home becomes the reservoir into which are poured all the resentment, disappointment, grief, and frustration associated with the unhappy experiences of the day. A tired, harassed mother finds in the family circle the only audience that cannot run out on her when she recites her trials and tribulations. A father at the close of a trying business day settles down at home with no feeling but indifference as his contribution to the family circle because he is preoccupied with expressing his grievances against those in authority, his irritation with his fellow workers, his feeling of failure, his anxiety about economic security. It is not surprising that the children in such a home soon regard it as the dumping ground of all unhappy and unhealthy adult emotions—a place used by all its inmates in their efforts to air the grievances against a world that has cheated them of something vital to their well-being. Such a home finds it difficult to compete with commercialized amusements—the dance hall, the night club, and motion-picture theaters.

Much good may come of talking over personal dissatisfactions in an orderly, intellectual way, but an unintelligent outpouring of grievances by a group of unhappy individuals seeking self-pity serves no useful purpose. Children who see in their parents unhappy, defeated, critical individuals do not want to be like them, nor are they inclined to find in their own home an ideal pattern for the future.

Unfortunately there are parents who have to live on such a low economic level that the problem of bare subsistence is confronting them at all times. When the clinic is faced with such a situation a relief agency must lay the foundation for any improvement involving mental hygiene. There are also parents whose intellectual equipment is so low that it would be beyond their compre-

hension to carry out even a common-sense program. For the problem child of such parents placement is absolutely essential. More numerous than any of these are, however, the parents whose own lives are so unstable emotionally that little or nothing constructive can be done for the child or for the family until the parents have recovered from their own mental difficulties. For this they need help, which may be provided either by referring them to some adult psychiatric clinic, or, if time permits and it seems wise, by treating the parents as well as the child at the habit clinic.

The child looks to his parents for his sense of security. In his parents he meets authority for the first time and his love relationship with them is constantly being endangered. He has to recognize that many of his desires are unattainable. In fact, it must seem to him at times that many of the goals which he is pursuing belong in the realm of the forbidden. He must learn to postpone the desire of the moment for that which his parents teach him is more worth while in the future. The habitual reactions with which the child meets these situations depend upon the wisdom with which his parents meet them. Parents who are still trying to meet the problems of adult life with the same emotional responses they used as children will obviously fail. Those who have had experiences deeply laden with emotion which are incompatible with their own ideals and supposed adult maturity, are suffering from a state of mind which necessarily affects their conduct toward their children. When the child's behavior sets off these potential emotional bombs, the task of developing adequate habits in the child is indeed a problem. The wise parent will make an effort to understand his own emotional life as well as that of the child.

The following case is a good example of a mother who brought a child to the clinic when the child should have brought the mother.

A woman about 40 years of age brought her little girl, 7 years old, to the clinic for examination, stating that she acted like a child 4 years old. The mother was unable to give any concrete examples of the child's immature acts. As far as could be discovered the child had no bad habits. She slept and ate well and was frank and honest. She would have liked to be affectionate if her mother had permitted her to be. She showed no cruel tendencies, and about the worst the mother could say was: "She takes up with any child she can find, regardless of creed, color, or nationality. I will not stand that." The mother stated that she would not permit her child to associate with the Catholic children in the neighborhood and that the Protestant children were not good enough.

The patient appeared to be a bright, keen, alert little girl, who answered all questions quickly and accurately. She manifested an interest in the examination and in her surroundings. She had an intelligence quotient of 98. As far as the history obtained from the mother and the examination of the child were concerned, there seemed to be little evidence to indicate that the child was either abnormal or unusual.

The mother was interviewed again, and it was ascertained that the child was not wanted, that the mother and father had been quite happy until her birth, and that she was looked upon as a stumbling-block to their happiness and economic success. The father's attitude toward the child was one of indifference. He rarely gave her any attention. The mother stated that she was not fond of her because the child was hateful and always made the mother regret being kind to her. When the mother and father were together they both ignored the child, and she was sent off by herself and not permitted to play with other children.

Further investigation of the case by the social-service department of the clinic revealed the following facts: The mother was looked upon in neighborhood as being "different." Although she was very affectionate toward her husband, the neighbors stated that it was not unusual for her to tell the child that she hated her. It was later ascertained that until a year before the patient was born

the mother was looked upon as a very desirable neighbor. About that time she went away to live with a man who had been a boarder in the house and returned to her husband only after the authorities made complaints. Shortly after her return the patient was born. Since that time the whole situation had changed.

One of the most pernicious influences to which a child is subjected is that of persistently interfering members of the family group. Grandparents are perhaps the worst offenders in this respect, although other relatives may complicate the problem of bringing up children quite as much, if they are so inclined. This is particularly true, of course, if these individuals are living in the same household, but not infrequently their influence is felt even when they reside at some distance. Too much stress cannot be laid on the necessity of having the right to discipline the child vested entirely in the parents. Nothing does more to lessen parental authority than to have some line of action which the parent has decided to carry out questioned in the presence of the child.

Another situation frequently arising with reference to the problem of discipline is that brought about by the divided household; that is, the inability of the parents to agree upon any plan of action for training the child, each one forming as the occasion arises a spontaneous judgment entirely on an emotional basis. Much of the difficulty arising because of divided opinion regarding some particular act of the child might be avoided if parents themselves could get some clearer idea of the relative importance of so-called misconduct in children. For example, all too frequently the same punishment is meted out for some quite accidental offense, such as breaking a window with a baseball, as would be given for some obviously voluntary, malicious act involving cruelty.

For the child who has the misfortune to have a physically handicapped parent—especially a mother—it is very important, on the one hand, that too much stress should not be laid upon her incapacities, and, on the other, that the child should appreciate at the earliest possible age the burden which the parent is carrying and the consideration to which she is entitled. One frequently sees problems of delinquency arising under these conditions because the parent has been physically unable to "make the children mind." Much can be done by appealing to the child's spirit of fair play, especially when the object of his sympathy is always before him.

All too often adults are prone to utilize what appears to be the most potent means of obtaining obedience from the child; namely, fear. As this is one of the most primitive and easily stimulated emotions it is used more freely perhaps than any other. "If you don't stop crying, I'll go back to the hospital again," is a threat of a convalescent parent. "Don't touch the telephone," a mother remarks. "It will bite you." "The policeman will get you if you are not good." "The doctor will put the stick down your throat if you don't answer his questions." Fortunately for the child's peace of mind he soon finds that such promises and threats are not to be taken seriously, but unfortunately he is unable to distinguish between the persons whom he can trust and believe and those whose advice and warnings are simply idle prattle. Consequently he is likely to develop an absolute disregard and disrespect for the opinions of others, and later in his life he will be insensitive to praise or blame.

Cheating the child by making promises which the parents know they cannot keep or which they have no intention of carrying out is perhaps the origin of the absolute disregard for truth and the exaggerated suspicion seen in many children at an early age.

"The doctor has a lot of nice things in his bag which he will give you if you stop crying," one mother was overheard to say. She followed this up with the statement that "Mother is going to buy you heaps of pretty things as soon as the doctor is through," and made other promises which obviously she had no intention of carrying out.

The parents who take time to understand their child, who know his responses to praise, blame, rewards, and punishments, and who are affectionate and tolerant without being unduly sentimental and spineless, are the ones who will have the most to offer their children. The child imitates the habits and attitudes of his parents. They are a constant source of suggestion to him at a period in life when he is most plastic.

HABIT PROBLEMS ASSOCIATED WITH EATING, SLEEPING, AND ELIMINATION

The physical well-being of the child is largely dependent on the efficiency of three fundamental organic functions; namely, eating, sleeping, and elimination. These functions become controlled and regulated by habit, and therefore habits of eating, sleeping, and elimination are the first to receive attention. The mother of the newborn infant is confronted with the dual responsibility of supplying proper nourishment and helping the infant to develop desirable habits for taking this nourishment at such times and in such ways as will best serve his physical needs. Almost at once she must also teach him to sleep at regular hours and without special attention; and, a little later, she tries to establish regular toilet habits. When these habits are properly established at a reasonable time, the child has been provided with a lasting foundation for both mental and physical health.

It is in connection with these simple physiological processes, however, that many of the initial mistakes in child training are made, either because parents ignore their importance entirely or because they become unduly worried and anxious over the difficulties encountered. The consequences of ignoring an undesirable habit are not always apparent. The immediate effect may be trivial compared with the ultimate results. On the other hand, oversolicitude on the part of parents introduces into their relationship with the child an indefinable something that the child assumes to be doubt, misgiving, or weakness, and that prevents him from looking to them for guidance, an essential factor in child training.

The methods recommended for establishing satisfactory habits in infancy are discussed elsewhere.² The discussion here is rather based on the fact that mistakes are made and undesirable habits formed. Inasmuch as these undesirable habits cause parents much concern and interfere with normal personality development, the habit clinics can be of valuable service to the community.

EATING HABITS

No problem causes parents more concern than that of the child who has difficulty in taking and digesting his food. The more common feeding problems are refusal of food, sucking of food after taking it into the mouth, regurgitation, and vomiting. The fact that parents develop a marked anxiety with reference to these difficulties makes them oversolicitous, and this, in itself, is a most important factor in perpetuating the difficulty. A part of the body which is easily affected by emotion is the gastrointestinal tract. Physiological research has established the fact that emotions of various sorts, such as fear, anger, and excitement, directly influence the flow of digestive secretions. It is therefore not surprising to find that an organism so

² See *Infant Care* (Children's Bureau Publication No. 8, 1938), pp. 44-49.

highly developed, yet so unstable, as that of the nervous system of the child may very clearly reveal the relation between psychogenic and physiological processes.

It is usually not difficult to pick out those children whose loss of appetite and inability to digest and assimilate food are due to psychogenic rather than physiological causes. Nevertheless, it is essential to have these cases clearly differentiated by careful physical examinations. Many children who come to the clinic because of difficulty in feeding are not poorly nourished, anemic individuals. On the contrary, their physical condition is frequently such that one sees little cause for anxiety until the history of the case is presented. In such cases it is found that although the child's intake of food is fairly good, the food is of such a quality and taken under such emotional stress that it fails to serve the child's needs. The mother states that the child absolutely refuses to take food unless she sits down by his side and actually carries out all the necessary motor processes to get the food from the plate to the child's mouth, and even then she may have to tease, coax, threaten, and sometimes punish the child in order to make him swallow the food. After satisfying herself that the proper amount of food has been taken by the child, the mother is naturally quite dismayed to have the food vomited before the child leaves the table. When one considers the effects of emotion upon the process of digestion, it is not surprising to find that under emotional strain the stomach rejects the food.

A somewhat different problem is presented by the child who becomes antagonistic toward certain types of food—as, for example, soups, cereals, or vegetables of a special color. Such antagonisms persisting over a long period of time may have been aroused by injudicious methods utilized the first time the food was presented to the child. There is no doubt that parents sometimes make a great mistake in forcing a child to eat some new food which they consider absolutely essential to his well-being, the parents themselves being dominated by the idea that unless they are successful at the first attempt the battle is lost. Under such conditions there is apt to be a very unpleasant emotional scene which will linger in the mind of the child and be recalled the next time the food is presented. It therefore seems wise to guard against making an event of introducing a new article of diet into the child's menu. The food should be presented without comment and without any evidence of doubt in the mind of the parent or nurse that it will be eaten. But if, for some reason known or unknown, it is not taken at that particular meal, an unpleasant scene should be avoided and it should be presented at a later date without comment or show of indecision.

A certain amount of manual dexterity is required before children are able to feed themselves, and all too often parents find it easier to feed the child than to teach him to feed himself. Feeding is one of the first complex acts which the child is called upon to do for himself, and it is not surprising that he accepts this new responsibility with a certain amount of reluctance. Usually, however, success brings with it a kind of satisfaction which stimulates the child to make further efforts toward accomplishing the task.

It is of paramount importance to avoid discussing the child's feeding habits in his presence. Such discussion tends to fix the

event in the mind of the child and make him cognizant of the fact that he is the center of attraction during the meal hour. Many children find that a negativistic attitude, not only toward feeding but toward sleeping, playing, and general obedience, is one way of attracting the attention which they desire.

Once the physiological causes of loss of appetite and malnutrition have been eliminated, it invariably works out well to serve the child only a small quantity of food, first making sure that it is well prepared and then allowing a sufficient period of time in which to eat it slowly. If it is not eaten, the food is removed at the end of that period without any ceremony, this procedure being repeated for a series of meals. Under those conditions much of the drama in which the child delights is eliminated, and much of the unpleasant emotional reaction produced by creating an antagonistic attitude in the youngster is avoided.

Some of the cases illustrating the difficulties associated with feeding will give more detail regarding the importance of neither directing the child's attention nor arousing his antagonistic attitude toward his food and the necessity of allaying the doubts and fears in the minds of parents so that they may at least appear less concerned.

Allen was brought to the clinic at the age of 3 years with the following history: Birth was difficult, necessitating the use of instruments; birth weight, 10 pounds; breast-fed; normal development; no illnesses or diseases. At the age of 2 he was treated with radium for a persistent thymus; at the time of the clinic visit he had enlarged adenoids and tonsils.

According to the mother this child never slept restfully but tossed and twisted about in his crib, often talking and crying out. He was extremely finicky about food and had marked likes and dislikes. He did not care for milk and refused vegetables, but he would sometimes eat seven apples a day. He was fond of meat, which was given to him occasionally. He never wanted the food set before him at mealtime.

He was considered somewhat shy and diffident, especially with strangers and adults. He played fairly well with other children on the street—usually with girls about 2 or 3 years older, but also with boys when he had the opportunity. He was fond of throwing a ball and wanted to be doing just what others were doing in games. He was very active. He was very fond of his mother and was often called "mother's boy." He was chummy with his father and most considerate toward his sister, 2 years younger than he. He was very selfish and most reluctant to divide things with others, always keeping the "lion's share" for himself. His mother stated that he was very stubborn and would not do as he was told, being, in fact, more likely to do the opposite. She punished him at times, but she believed that a more effective method of discipline was the threat to leave him.

At the clinic the child was keen and responsive. He answered all questions quickly and in detail, cooperated well, and was interested in the tests. He enjoyed being the center of attention and was very pleasant and kindly about it all. He paid much attention to his mother and little sister. His intelligence quotient was 130, and his mental capacity 1 year ahead of his chronological age.

There seemed to be nothing unusual or significant in the home situation. Both parents were fairly intelligent, very friendly, and cooperative. Although the father was an occasional drinker, he never came home drunk, nor was he a man of dissipated habits. The parents were working together for the good of their children. The father's salary was adequate. The family occupied a four-room apartment which was in good condition and well kept. The furnishings were of the average type.

Summary.—It appeared that this child, 3 years 4 months of age, was of rather superior intellectual endowment. His environment presented nothing outstanding in the way of a social problem at the time of the examination. The principal anxiety of the parents was the feeding problem, the child being poorly nourished and underweight, extremely finicky about food, showing

strong likes and dislikes for various articles of food. The child was stubborn and very negativistic. He rebelled against authority whenever he was thwarted and whined a great deal.

The first and most important step in the treatment of this case appeared to be the regulation of the sleeping hours, it being perfectly obvious that a child of 3 years should retire before 10 p. m. The mother was instructed that before any improvement could be expected the child must be trained to go to bed at 7 o'clock and have at least 12 hours of sleep. She was warned of the initial difficulty in trying to put this new program into operation and was given a careful explanation of how much easier it would be to institute such a program at this time than 2 or 3 years later. Her cooperation was thus assured.

The next step necessitated a rather long, detailed explanation to the mother of the means and methods which children use at an early age to obtain their own way. The futility of trying to get the child established on a proper diet while giving him apples and candy whenever he refused to take milk and vegetables was pointed out to her. She was also advised that just so long as stubbornness served the child as a means of obtaining what he desired just so long would he utilize that method; and that it was extremely important for him at this age to learn that whining and rebelling would not serve as a method of gaining his own ends. A diet was carefully prescribed, and the mother was instructed to place only moderate portions of food before the child at each meal. She agreed that the food should be left before him for a period sufficiently long to permit him to eat slowly, yet not long enough to permit him to play with it, and that it was then to be removed. She also promised that he would receive nothing between meals except the extra milk which was prescribed in the diet because of his being underweight. The parents were in no way to concern themselves with what the child was eating. A careful record of the success or failure of the treatment was to be kept on a chart. The entire plan was explained to the child as simply and concisely as possible.

The results in this case alternated between success and failure for 5 months. Cooperation of the mother during the first part of the treatment was not all that had been hoped, but each time she returned to the clinic, regardless of whether success or failure had been reported, renewed efforts were made to have her carry out in detail the plan outlined.

At the end of 6 months the following report was made: "The child is doing remarkably well; eats all vegetables including carrots, spinach, and string beans; still has a strong dislike for milk but takes one glass per day." A month later the report read: "Patient continues to take his food without difficulty; has shown marked physical improvement; takes great interest in presenting his chart, which shows a perfect record for the last 2 weeks; is much less negativistic; is no longer shy; and takes great pride in telling the physician of his improvement."

With the establishment of proper sleeping hours and feeding habits, the child became more obedient and less selfish and lost many minor neurotic manifestations, such as nail biting, whining, and restlessness at night.

Comment.—This case is particularly interesting because success in treatment came only after a period of 5 months, during which time the outlook seemed rather discouraging. It emphasizes the importance of persistent and continued education of the parents in a certain group of cases where cooperation is not of the best and where suggestion is not accepted readily by the child. The results, however, justified the efforts.

Barbara, aged 6 years 9 months, was brought to the clinic by her mother because of persistent vomiting and enuresis.

The child's history was as follows: Normal birth, full term. Development retarded; walking delayed until child was over 2 years of age; speech still quite indistinct; teething delayed. Illness included pneumonia at 2 months, whooping cough at 2 years, influenza, and chickenpox. Child subject to coughs and colds.

The child slept and ate well and had no history of any undesirable habits with the exception of enuresis both day and night and persistent vomiting after meals, a habit which began about 4 weeks before the first clinic contact.

The child was described as shy and unwilling to speak unless spoken to, even at school. She frequently hung her head when spoken to by her teacher

and refused to answer. She was extremely selfish and was jealous of the other children. At home she was quarrelsome, but outside the home she got along without difficulty. She seemed to have a normal interest in other members of the family with the exception of the younger sister, Susan, toward whom she was very antagonistic.

At the clinic she seemed to be a dull, apathetic child who hung her head and refused to look at the examiner. She was lacking in self-confidence and displayed absolutely no interest in her surroundings. One felt at once that there was a problem of mental deficiency. This impression was borne out by subsequent tests and psychometric examination, her intelligence quotient being 64, which seemed a fair indication of her mental equipment.

The home environment was poor. The family lived in a very narrow tenement street. They had an apartment of three rooms which were very untidy, with dirty clothing lying about on the floor. The hand towels and dish towels were very much soiled. A pail in one corner of the kitchen was used as a toilet. The mother and the youngest child, aged 2 years, shared a double bed, and the father, the patient, and Susan slept in another double bed. They had lived in this place for 5 years. Although conditions were extremely poor, they had shown considerable improvement during the last few years. Previously the family had lived in one room and was very much in debt. The father had been drinking; the mother had taken no interest whatever in the children. At the time of the clinic visit the father had stopped drinking, the mother was taking more interest in the children, and they were no longer in debt.

The patient was brought to the clinic because of persistent vomiting, which began about 4 weeks prior to the visit, and for enuresis, which had been almost continuous since birth. No attempt had ever been made to establish a routine that would break up the latter habit.

It was not difficult to determine how the vomiting had its origin. The mother was pregnant and had been vomiting during the preceding months, frequently in the presence of the child. How much of the behavior of the child was imitation and how much was stimulated by the physiological reaction of seeing another vomit was difficult to say. However, as soon as the mother was instructed about the necessity of seeking privacy during these vomiting periods, and after it was explained to the child (although she was mentally deficient) how unnecessary it was to persist in this habit and how foolish it would be for her to continue to take food if she persisted in throwing it up immediately, the problem seemed to be solved, for within 2 weeks the vomiting ceased completely.

Further investigation showed that Susan, 2 years younger and of higher intelligence, was also troubled with bed-wetting at night. The routine corrective measures were at once instituted for both children. A chart system was introduced and rivalry was stimulated between them. The results in both cases were extremely satisfactory.

Another youngster was subsequently added to the household, making four children in all. When the oldest was just over 7 the mother found it necessary to go out to work and took a job cleaning a theater at night. She left the house at 10:30 p. m. and worked for 8 hours, sleeping most of the day. She well represents the type of mother who is worn and wearied by toil and who has little to contribute to the welfare of the home. She was, however, extremely grateful to have her burdens lightened as much as they were. Both children continued to visit the clinic at frequent intervals, the mother feeling that they were more easily disciplined when they had to make a report to the clinic occasionally.

Comment.—The interesting point in this case is that it shows how important imitation is in the mental development of children and also that feeble-minded children do respond well to the simple training method.

Carrie came to the clinic at the age of 5½ years. Birth and development were quite normal. There was nothing of significance in her history nor in the physical examination made at the time of the first visit to the clinic.

The patient was brought to the clinic by her aunt, who stated that she would not eat unless fed, that she held her food in her mouth, and that she persisted in regurgitating it. When left alone at her meals and told to eat she invariably hid the food and told fanciful tales about what had become of it. On one occasion when she was told to eat her breakfast, she hid the food on the attic

stairs and said she had eaten it. When taken to her uncle's store and given crackers she secreted them on her person and then threw them away, sometimes hiding them behind barrels in the store but always insisting that she had consumed them. She was said to be able to play all day without food. There was, however, no difficulty in getting her to eat ice cream and candy.

The child's father and mother had both died during an influenza epidemic, when she was 2 years of age. At that time the patient had been taken by the aunt and uncle, with whom she had continued to live. These relatives were apparently devoted to her and were as seriously interested in her welfare as in that of their own child. At the time of her parents' death she had not learned to feed herself, and the struggle to teach her had persisted ever since. She had formed the habit of not eating unless her aunt sat down and fed her, which meant cutting up the food and conveying the morsels from the plate to her mouth. More recently the child had begun simply to hold the food in her mouth, refusing to swallow it. The aunt reported that breakfast was a daily ordeal, as she felt that the child must be forced to eat before going to school. She further stated that Carrie had gone beyond all limits of the normal hunger period for the ordinary child. Except for her capriciousness regarding food, there seemed to be no undesirable habits. She slept well, was ordinarily obedient, had well-established toilet habits, and seemed to have no particular defects in her personality make-up.

At the clinic Carrie did not appear at all undernourished and seemed to be happy and cheerful. Her only comment regarding not eating was as follows: "I dream of a beautiful fairy in yellow who told me that I should not drink milk." After having a careful physical examination, however, the child did drink a glass of milk and eat a half slice of stale bread without any hesitation.

The aunt was instructed not to be so solicitous over the child's meals. She was told to prepare the food and place small quantities of it before the child, telling her that she would have 15 or 20 minutes to eat her meal and that it would then be taken away and she would have nothing else until the next meal. She was strongly urged to carry out these instructions faithfully until she came to the clinic the following week.

The problem was also discussed with the child, an effort being made to impress her with the importance of taking her food at regular intervals and also of eating it without assistance from her aunt. The following week the aunt reported to the clinic that the patient got along well for the first 4 days after their visit but that since then "has been carrying on pretty much the same way as she always has." She found it more difficult to discipline the patient than her own child and clung tenaciously to the idea that she wanted to do for the child what the child's mother would have had her do. One could see that she was activated by the idea that she wished to avoid showing any partiality toward her own child.

The family lived in a comfortable, sunny apartment, which, however, was kept in an extremely untidy state. When the social worker visited the home, the table was piled with dirty dishes and half-eaten food, and such food as could be seen in various pans looked most unattractive and poorly cooked. The floor was unswept, and there were large pails full of unwashed clothes standing about. The aunt's clothing and person were dirty, as were those of the children. At this time the aunt felt that she was at the end of her resources with regard to the patient and said, "I wouldn't mind trying to feed her if she would only eat what I feed her." Yet she seemed glad to have the child as a member of the family, in spite of her difficulties. She felt that the child had been spoiled by her own parents, who had lost an older child as the result of an accident when the patient was 1 year of age. This had undoubtedly made the patient's mother very solicitous and anxious, and the child had been permitted to have her own way. The aunt stated that she felt the child's difficulties with eating were getting worse, rather than better.

It seemed impossible in this particular case to organize the child's routines in a satisfactory way in her own environment, and an effort was therefore made to remove her from her surroundings until normal eating habits could be established. This was accomplished by sending the patient to live with another aunt in one of the nearby suburbs when the aunt with whom she had lived went to the hospital to be confined. While living in the new environment she did extremely well and no eating problem was evident. Shortly after returning home, however, she resumed her old habits. Attempts were made to persuade both the aunt and the uncle to have the child go to the study home of a local

child-welfare agency for an extended period, but their attachment to the girl and their inability to appreciate the gravity of the situation made such attempts futile.

HABITS OF ELIMINATION

The function of elimination frequently becomes the center of undesirable behavior, ranging in seriousness from simple delay in establishing toilet habits to serious neurotic manifestations and perversions. The most common problem concerned with elimination is enuresis, and as this is the type of behavior for which habit training is particularly important and with which it is very successful, the discussion will be largely limited to this.

Enuresis may occur both day and night. It occurs in both sexes with about the same frequency. It may begin in infancy and last until the sixth or seventh year, or it may cease at the end of the first year with the condition returning at indefinite periods and lasting from a few days to a few months at a time. Doctors Holt and Howland state, "Probably the most important cause is habit, resulting from poor training. Habit is often a potent factor in continuing the incontinence, even after the primary cause has disappeared."³ It is with this group of cases that the habit clinics are concerned.

Before starting to treat enuresis as an undesirable habit, it is, of course, necessary to eliminate, so far as possible, every organic cause for the condition. Conditions affecting the bladder, acute inflammations, and calculi are the most common causes. An adherent prepuce (phimosis), a narrow urethral meatus, or local irritations from worms or fissures in the rectum may be the cause. Enuresis may be associated with a highly concentrated acid urine when the fluid intake has been insufficient, or it may be brought about by increasing the fluid intake, which naturally increases the amount of fluid to be excreted. The more general conditions, anemia, malnutrition, and an unstable nervous system (of which enuresis is only a symptom), should receive proper consideration.

After all organic conditions have been excluded as causes of the enuresis there still remains a large group of cases which are dependent upon faulty habit formation for their cause and persistence. Even in those cases where definite physical causes have been found and cured, the condition may persist from habit.

There are certain general principles that may be applied in every case of enuresis. The child should so far as possible be following a regime that is free from any excessive mental strain. He should have a simple, bland diet and definite hours of sleep. Routine measures should be instituted to avoid constipation and to stimulate free elimination through other sources than the kidneys. One of the first and most important steps in the treatment of enuresis is to interest the child in making an effort to overcome the habit. This should be brought about by appealing to the child's love of approbation rather than through punishment or humiliation. The chart system has been utilized with success in this connection. Not only does a chart serve to keep a definite record of the child's achievement during the interval that he is away from the clinic, but in a way it serves as a motive for

³Holt, L. Emmett, M. D., and John Howland, M. D.: *The Diseases of Infancy and Childhood*, p. 647. Tenth Edition. D. Appleton & Co., New York [1933].

the effort needed to overcome the habit. The child keeps his own chart, makes a mark for each day and night of success, and over each mark a star is placed. In a certain group of cases, suggestion, when the child is going to sleep at night, has worked well. The mother sits down by the bedside of the child and just as he is about to fall asleep she has him repeat over and over again, "I am not going to wet the bed." This suggestive treatment is similar to hypnotism, which has been used successfully in many adult cases and which lends itself quite easily to home treatment.

Not infrequently one finds that parents for one reason or another have taken for granted that a particular child will continue his habit of bed-wetting long after the time when he should have been trained to the dry habit. One mother stated that she herself had wet the bed until after she reached of age of puberty and for this reason she had ignored the problem in her 7-year-old daughter. Another mother explained that the child had inherited weak kidneys from the father's side of the family, the patient's grandfather and father having both been troubled in this way. A third mother reported that none of her four children was "dry" before reaching the age of 5 years and that she just assumed that the patient, who had come to the clinic because of night terrors, should also be wetting the bed at $4\frac{1}{2}$ years of age. Such an attitude in parents invariably prevents them from starting on any intelligent plan of training; indeed, they often seem to get a feeling of satisfaction when their half-hearted attempts at training fail.

It is not unusual to find children reverting to the habit of enuresis despite adequate training. A little girl, 4 years old, who became intensely jealous of the newborn baby, began wetting her bed and her clothes again after having overcome this habit more than a year before. Another little girl who was devoted to her nurse began wetting the bed when the nurse left her to care for a younger child. Peter, aged 6, found that the bed-wetting of his younger sister, aged 4, got so much attention that he began the same performance after having been perfectly trained for $3\frac{1}{2}$ years.

One must keep in mind that there are many emotional and environmental situations which are related to enuresis, especially in those cases in which the child has been "dry" for a long period. Notwithstanding the fact that punishment and humiliation are not usually successful as methods of treatment, it is perfectly fair and just to impose upon the child a certain amount of care and responsibility which go with looking after the soiled linen. Such tasks as putting the clothes to soak, airing the bed, and washing off the rubber sheet, should be handed out, not as punishment, but rather as aids to correct a difficult situation. It may, however, provide the essential motive if the child is to take the problem seriously enough to make it worth his while to get over the habit.

It is also wise to point out to children the disadvantages associated with the habit of bed-wetting. It prevents overnight visits to friends and relatives and perhaps riding on trains. It is frequently an obstacle to the child's privilege of having overnight guests or of going away to camp. These disadvantages should be presented as reasons why every effort should be made to overcome the habit and not as threats against its continuance.

Daniel, first seen at the age of 5 years 2 months. Born at full term; birth weight, 7 pounds; breast-fed; development normal.

He was in the habit of going to bed at 6 p. m.; slept alone; was restless only on rare occasions, when he would talk during sleep. He was not finicky about food; had a good appetite and no history of constipation or indigestion.

His mother stated that trouble began when he was 2 years of age. At that time he was very ill with pneumonia. Following this illness he began to soil himself and wet his clothes and his bed. This condition persisted for 2 years, but for the last year and a half he had been troubled with enuresis only at night. This occurred about 5 nights out of 7. The mother stated that she had spanked him, rubbed his nose in the urine, and deprived him of things, and at the time of her clinic visit she was refusing to give him clean pajamas over long periods of time, trying to impress him with the fact that he must learn not to wet his bed.

The child was generous and friendly, liked other people, played with other children, and was not jealous. He was inclined to be obstinate and could not be driven, but could be easily disciplined if coaxed. The child had no particular fears and enjoyed playing outdoors with other children. On the other hand he spent much of his time playing dolls with his little sister.

In his psychological examination he received an intelligence quotient of 92. He was fairly cooperative but inclined to be boastful, constantly saying, "I can do this," "I can draw that." He was particularly interested in drawing. In fact, it was difficult to hold his attention because of his interest in making pictures. He was attending kindergarten and preferred going to school to staying at home.

The home environment was quite satisfactory, the family occupying a small house consisting of five rooms. The home was clean, tidy, and attractive; each child had a room to himself. The mother was interested in her children and ambitious for them, looking forward to getting a larger house and a yard for them to play in, where they would be away from the dangers of automobiles. She was, however, of a neurotic make-up, having had two nervous break-downs. The father was in a successful business with his brother, earning an adequate salary. The two children were both in good health and enjoyed each other's company. The mother was in fairly good health at the time of the visit to the clinic.

Summary.—Child, 5½ years of age, with an average intellectual equipment, coming from a good home, troubled with enuresis 5 nights out of 7, with no other undesirable habits. The treatment, to date, had consisted of cruel humiliation and severe punishment.

The fact that the patient had been treated at numerous clinics led the mother to believe that the case was hopeless. She maintained that she had carried out all the directions given her by the physicians, but in spite of this the enuresis continued.

The boy, as seen at the clinic, was attractive and bright, interested in his environment, and anxious to demonstrate his ability in printing and drawing. He discussed his problem openly and frankly, without any apparent embarrassment, and expressed willingness to cooperate. Physical examination and laboratory examination of urine were both negative.

The routine treatment for enuresis was outlined as follows: The patient's diet was to be simple, free from spices and sweets, with only a moderate amount of meat; his evening meal was to be served at 5 p. m., after which he was to have no fluids. He was to retire at 7 p. m. He was to be taken up, thoroughly awakened, and sent to the toilet at 8:30 and again at 10, and then permitted to sleep until morning, when he was to be awakened at 6 o'clock. Stress was laid on the fact that the child must be thoroughly awakened and made to realize why he was being aroused. The mother was warned to be sure that the child voided when he was taken up. A chart was then brought out and given to the boy, and the method of keeping the record was carefully explained.

The child responded to his part of the program with much enthusiasm, but the mother showed considerable skepticism about the routine outlined. They returned to the clinic 1 week later, and at that time it was apparent that she had not carried out the directions, in spite of her statements to the contrary. She had instituted her own treatment with kidney pills. She was, however, prevailed upon to continue the prescribed routine for a month and was requested to visit the clinic each week. The report of the next visit to the clinic read: "She is much pleased with the change that has taken place in the patient, feel-

ing that the chart brought it about. She is anxious that the younger child, aged $2\frac{1}{2}$ years, be admitted to the clinic for the same trouble. She states that she did not continue to experiment with a patent medicine but decided to follow the advice given."

The next time she brought both children. She reported that the bed-wetting had completely ceased and that she was greatly relieved.

Comment.—The only comments that need be made on the above case are in reference to the tactfulness necessary in getting cooperation from the parents and in making them feel that, although they have tried various remedies at different times, they have perhaps never put into operation any plan that took into consideration all the aspects of the individual case.

This case of enuresis was uncomplicated by any other nervous symptoms or undesirable habits, and it is worthy of note that the enthusiasm which the child showed in keeping the chart was, in itself, favorable from a prognostic point of view.

Another case of this type was that of Ellen, aged 3 years 9 months when first seen at the clinic. The patient was born at full term; birth and development were normal; she was breast-fed to the age of 11 months.

The child's hours in bed were from 7:30 p. m. to 6 a. m. Sometime previous to the clinic visit she began waking up during the night; she seemed frightened, cried out, and talked about soldiers. She had always been finicky about food. She would not take milk until she started attending nursery school, but she had since developed a liking for milk and ate everything except meat. She did not eat between meals.

The patient was very shy and said nothing in the presence of strangers but clung to her mother. She was very quiet, and her mother stated that she was capable of entertaining herself. When younger, she had had a very bad temper and had frequently gone into tantrums. She was extremely jealous of her younger brother. This jealousy was carried so far that when her mother had first begun to nurse him the patient had not lost an opportunity to slap or otherwise bother him. She did not care to play with other children and was self-centered and retiring. She was obedient and rarely had to be disciplined. Her play life was occupied largely with her dolls, occasionally with her brother, and rarely with other children.

The patient had an intelligence quotient of 84. She attended kindergarten, where she was getting on fairly well.

The home consisted of a five-room tenement on the second floor of a three-story brick building. The family had lived there for 8 years. It was clean, and although in poor condition, well furnished. The patient had a room to herself. She was more attached to her father than to her mother and lacked normal interest in her brother.

The problem as described by the mother was enuresis, which occurred both day and night. This condition had persisted since birth. For a long time there had been difficulty in sleeping. The child was put to bed at 7:30 p. m. and usually went to sleep within half an hour. She woke up at 1 or 2 a. m. and then every hour thereafter until 6 o'clock, when she insisted on getting up. This wakefulness, accompanied by crying, had become a very disturbing factor in the household. For the 3 preceding weeks the child had developed an unusual fear of soldiers and upon waking cried out in fear, saying, "Don't let the soldiers get me!" The story was that she had been taken by her mother to see some soldiers drilling. This had alarmed her for some unknown reason, and since that time she had talked constantly about soldiers, saying that they were going to take her away. When she awoke at night she cried out to her mother, "Close the door, the soldiers are coming!" She refused to go into any room alone since this event and wanted her mother constantly by her side. She had become much afraid of the dark.

At her first visit to the clinic she was extremely shy and would have nothing to do with the examiner, speaking only to her mother in whispers. She resented any attempt of the doctor to become friendly, and because of this timidity the first clinic visit was unsatisfactory.

Routine measures for the enuresis were instituted, however, as described in the preceding case, except that the child was permitted to go to bed at the usual hour of 7:30, was awakened at 10, and was permitted to sleep until morning.

The mother was instructed to take the child again to see the soldiers drilling and allow her to observe them as closely as her fear would permit. The mother was told to assure her and to instruct her about soldiers.

At the end of the month the mother reported that the child had shown considerable improvement and had not wet the bed for 2 weeks, had slept better, and was no longer afraid of soldiers. The fact that the mother had taken her to see the soldiers drill every day seemed to dissipate her fears. The child was more friendly toward the doctor but was still shy and bashful.

Improvement continued during the summer months, and in September the child entered kindergarten. The teacher reported that she got along well, showed normal interest, and adapted herself to the school work. She enjoyed the association with other children, was quite unselfish, well-mannered, and obedient. The mother reported that the patient was getting along very well—that she did not wet the bed and that she had no difficulty about her eating. She no longer entertained any fear that disturbed her either day or night.

Comment.—It was interesting in this case to note the degree to which this child was able to make satisfactory adjustment to both home and school conditions. She became relatively independent of her mother and interested and affectionate toward her little brother. She was sleeping well, her appetite was good, she had no difficulty with enuresis, nor was she any longer disturbed by fears and terrifying dreams.

Although it was impossible in this particular case to determine the underlying cause of the terrifying wakeful periods, it is of interest to note that many favorable changes took place subsequent to, if not simultaneously with, the treatment of the enuresis. This happens so frequently in the treatment of this disorder that it leads one to believe that the feeling of inferiority and shame associated with enuresis in many cases colors the entire mental life of the patient. It is of practical importance in the treatment of mental problems where enuresis happens to be one of the symptoms (inasmuch as enuresis is one of the most trying problems to the parent, although one of the most easily curable) to institute treatment for the enuresis at the earliest possible date.

HABITS OF SLEEP

Most of the problems that arise in relation to sleep are brought about by poor training or lack of training on the part of parents. Children frequently get the idea that bed is a place to be avoided, because it has been used as a means of punishment. When Mary is naughty, she is threatened with being sent to bed. Tommy, on the other hand, is told that if he is good he may stay up a half hour later. Both attitudes imply that bed is a place to be avoided.

A sleep routine should be established to which parents and child will conform, for there is no demand made upon the physical well-being of the child in which sleep and relief from physical fatigue do not play important parts. The tired child is usually an unhappy child. Tantrums, enuresis, stammering, various mannerisms, and numerous other physical and emotional problems are frequently caused by fatigue due to insufficient sleep.

The importance of sleep should be taken for granted, neither featured nor ignored, and the parents' attitude should be precisely as it is toward the meal hours. The hour for retiring should not be permitted to be a time for "putting on a show" and getting attention. The child will soon learn that after he has been adequately prepared for bed, comfortably tucked in, and had his parting "good night" said, the ceremony is over and a belated request for a story, a trip to the bathroom, or another drink of water is just a way of trying to get attention or exert a little influence over the solicitous mother. Yielding to such requests is the beginning of an indulgence on the

part of parents that may cause them much trouble later and create in the child a feeling of dependency that will prove a real handicap.

The overtired child or the child who is said to be suffering from growing pains may exhibit considerable restlessness—tossing, turning, twisting about, and complaining of not feeling rested the next day. These periods of physical unrest need not cause parents undue anxiety. They are indications that there is need for more rest, less violent physical exercise, and perhaps a warm relaxing bath before retiring. Night terrors, so called, are a matter of deeper concern because they are invariably related to some disturbance in the psychic life of the child. There is no doubt that many fears are planted during the early life of the child, are awakened by subsequent experiences, and eventually play an important part in producing night terrors. Children should not be threatened with violence of one kind or another for indiscretions, because the anticipation of punishment, like threats from other children, may lead to serious disturbance of sleep.

Not infrequently intelligent parents create sleeping difficulties for the child by reciting to him, just before he retires, stories that are tinged with the mysterious and the unexpected. They often leave him in suspense in some very exciting part of the story in order that a happy experience may be anticipated the following evening. It is obvious that such a proceeding is unwise for the imaginative child. The mental activities created in this way often prevent the child from going to sleep and frequently create both motor and mental unrest. Many programs presented over the radio at the present time are of this nature and lay the foundation for a bad night, which is followed by fatigue and irritability the next day. Many children have strange, vague, ill-defined worries and anxieties over death, sickness, school, and parental relationships. Strong emotional tension is associated with these worries and they assume undue proportions in the mind of the child after he has withdrawn from the day's activities which have been demanding his attention. Threats of punishment, fear of being deserted by parents, or of being subjected to bullying and teasing by other children, and many other everyday environmental situations which threaten the child's security are subjects that are worthy of investigation when one is endeavoring to solve a problem related to sleep.

As the child advances to the age when he is able to read and comprehend sensational newspaper headings relating to lurid tales of murder, suicide, robbery, immorality, and other topics that excite curiosity, a new factor is introduced which often disturbs his mental life and results in sleepless nights. Fortunately, much of the material derived from radios, newspapers, and other contacts which the child must make in his everyday existence, does not register on his mind before his fifth or sixth year. All these new avenues of enlightenment make a valuable contribution to mankind in general, but they are a menace to a certain group of highly sensitive, imaginative children. It hardly seems necessary to mention that fear stimulated by putting children in dark closets and down in the cellar, by threatening them with unusual punishments, and by scaring them with weird tales, is cruel and vicious and leaves scars upon their mental life that are rarely completely healed and that may lead to the most

violent type of night terrors. Some children are extremely sensitive and sympathetic to the worries and anxieties of parents, and during periods of extreme economic depression, when the security of the entire family is threatened, when there is grave illness in the home, or when undue emotional tension exists between parents, a state of mind is created in the child that frequently prevents normal sleep.

Besides creating a happy, carefree, unperturbed state of mind for the child before retiring, it is also important to provide proper sleeping arrangements. The bed itself should be neat, clean, and orderly in appearance, with clothing suitable to the season. In other words, it should have an inviting appearance. The room should be well ventilated but not necessarily cold or drafty. The shades should be drawn so as to avoid bright early-morning light. Some of the minor details such as the type of night clothes, placement of bed, and arrangement of furniture can be left to the child when feasible. The act of retiring should be taken for granted, featured neither as one of the crosses that children have to bear nor as an unusual privilege, but as one of the events that take place in the routine of a happy day. The matter of adequate sleep is a subject that cannot be ignored in any consideration of the mental and physical welfare of the child, especially during the first few years when habits are being established. Sleep is nature's way of conserving the child's energy against the demands made upon it by rapid physical and mental growth.

John, a 2-year-old boy, was referred to the clinic because of irregular sleeping habits, enuresis, soiling, irregular and finicky feeding habits, and disobedience. His birth and development were normal, and his intellectual equipment was average. His parents were young and unintelligent. He had developed into an undisciplined and untrained child. The mother had never made any attempt to train the child to toilet habits, and the irregularity of his eating had been taken for granted. In other words, the child ate when he felt hungry rather than when food was served to the other members of the family. His mother could not remember that the child had ever slept well. She stated that he was put to bed at 7 o'clock but rarely went to sleep before 2 or 3 in the morning. He insisted on getting out of bed and going into the living room to join his parents. In spite of their efforts, which were undoubtedly feeble and misdirected, he would stay up until 12 or 1 o'clock. He rarely slept later than 6:30 in the morning, at which time he would get up to have breakfast with his father. He then returned to bed and slept until 12.

The child was irritable, demanding, and extremely difficult to get along with. Whenever he was crossed or an effort was made to get his cooperation in doing something that did not please him, he would cry; and at the age of 2 he had already found that tears were apt to get him out of many difficult situations.

The mother was a weak, negative sort of individual, entirely lacking in imagination, who took little care of her own health or personal appearance, and who was a poor housekeeper and a bad manager. She was inconsistent in her discipline, so that in one mood she tried to control the child by cuffing and slapping him and in another mood she would indulge him in everything. When she slapped him, he slapped back; when she was resentful, he, too, was resentful. In other words the mother had settled down to a rather childish, infantile, emotional level, as was shown in her efforts to control the child with threats of the doctor, the nurse, "the cop," and anything else that might for the moment have affected the child's conduct. The problem was obviously one of parental education and of getting the child into a nursery school where he could live in a well-organized environment for at least part of the day.

Sarah was a tall, undernourished girl just under 5 years of age. She was brought to the clinic by her mother because of night terrors which had existed since infancy. For the first 6 months she had been difficult to feed, became

much undernourished, and had suffered from constipation; otherwise her development was normal. The feeding difficulty had, however, continued to manifest itself in indifference to food. She apparently enjoyed the attention that was associated with being fed by her mother, who indulged her in this respect.

This child, only 5 years of age, was frequently allowed to stay up in the summertime until 9:30, although she did go to bed somewhat earlier in the winter. Retiring was usually accompanied by a good deal of talking and laughing with her brother, who slept in the same room. The mother stated, "Nearly every night Sarah has night terrors. After a half hour to an hour of sleep she starts screaming and will yell out, 'I won't do it,' 'I don't like you,' or some other similar expression." The mother found it difficult to awaken her during these times. There was usually a short crying spell, and then the child would finally settle down and go to sleep. These episodes would be repeated several times during the night, but the child would have no recollection of terrifying dreams nor could she remember much about what had happened during the night. These night terrors were invariably worse when she was sick, but the mother had been unable to associate them with any actual experiences.

The mother described Sarah as "a high-strung, nervous child." At the clinic the psychological examination showed that she had a superior intelligence, rating 2 years above her chronological age. Her cooperation was excellent and her general behavior indicated excellent training and manners. The home from which the child came was above the average economically and culturally, and the parents were rather superior intellectually—in fact, the mother was "an amateur student of psychology and child training." It appeared, however, that the parents' influence on their child had been counteracted by that of the grandmother, who was said to be psychotic and who insisted upon "smothering" the patient with her affections and attentions, which the patient resented. The relationship with her grandmother was of such a nature that this ordinarily quiet, well-behaved, sensitive child resented it and made every effort to repel the grandmother's advances by assuming a domineering attitude herself. The mother was advised to regulate the patient's routine so that she would have adequate sleep, more rest, and regular meals; to eliminate so far as possible the contact between the patient and her grandmother; to see that the child was kept interested and occupied; and to secure the cooperation of her maid in this plan. The child was placed in a kindergarten in an effort to provide a routine suited to her needs, and to bring her in contact with intelligent and unemotional adults as well as a normal group of children of her own age. The mother reported at the end of 2 months that the night terrors had disappeared.

RESENTMENT TOWARD FRUSTRATION EXPRESSED IN AGGRESSIVE ACTS

The ways in which the behavior of children brings them into conflict with their constantly changing environment are many and varied. Equally numerous and varied are the causes of this behavior. For example, a child may present a picture of restlessness, destructiveness, pugnacity, and marked impulsiveness, with other evidences that he lacks normal inhibitions. Such behavior may have its basis in certain organic defects either inherited or acquired at an early age, mental deficiency being a classic example of this group; or it may be a reaction to physical limitations associated with diabetes, infantile paralysis, or cardiac conditions. Not infrequently acute inflammatory conditions of the brain or its coverings resulting in meningitis and encephalitis (commonly known as sleeping sickness) are followed by such disturbances in the child's behavior, due to impairment of the normal processes leading to inhibition. Very often, however, these difficult behavior problems are not due to any of the causes mentioned, but are the result of poor training or lack of training. In this case one sees an undisciplined child who undoubtedly has the ability but has never learned the necessity of exerting what are commonly known as will power and self-control.

Nor is the behavior of the child always constant. For a period, at least, offensive attitudes may alternate with defensive, and the child may put up a good fight against personalities and situations that are too strong. There may be vague, intangible situations which are overpowering to him. Rebellion may be of no avail against the subtleties of a persistently oversolicitous parent. The child will finally succumb to defeat and accept a plan of life ill suited to his needs and necessitating much in the way of fantasy to make it tolerable. What appears to be simply an undesirable habit such as enuresis may have its roots deeply seated in jealousy. Cruelty may be regarded by the parent as "just ordinary meanness" when actually it is an unconscious protest of the child against his own inadequacies. The sullen, unhappy child, apparently lacking in affection for anyone, may be crying aloud for someone who will take time to find out what his emotional needs really are and to see that some effort is made to satisfy them.

The varied responses which human beings make to life do not lend themselves well to any rigid classification. Because there is wide diversity in the constitutional make-up of individuals, and because these individuals are called upon to adjust themselves to environments that are varied and constantly changing, situations are created which are necessarily extremely variable and complex. It is with great difficulty and always with more or less danger that broad generalizations are set forth to be applied to the individual case. Every child must be considered as a living organism struggling to make

such adjustments to his environment as will permit him to survive and enjoy natural growth and development and to accept and conform to the restrictions which society imposes upon his behavior. Acquisition of the personality traits that lead to conformity is insisted upon by those who are responsible for the orderly growth and development of the child. It is the function of child training, so far as the wisdom and ability of parents permit, to see that the child is mentally and physically equipped to meet the world outside the home. Society deals harshly with those who fail to recognize the necessity of subordinating self to the social group. Unfortunately, force rather than understanding is too frequently exerted in efforts to make children conform. Fear is often in the foreground of most parental and social doctrines. The child is taught at an early age that the way of the transgressor is hard, and yet in spite of all this pressure exerted from without, the world is full of unhappy, inadequate, poorly adjusted individuals who have not profited by their early training. The question arises whether education should not be substituted for fear.

From the clinical point of view there are three distinct groups of problems of this kind: (1) There is the group represented by the child who because of certain limitations of intellect, physical defects, or emotional instability will be a problem regardless of his environment. (2) There is the child who, in the process of growing up, goes through phases involving certain changes in behavior which cause concern to his parents. These situations are not so much the problems of the particular child as problems of a particular stage of development, and, if handled wisely, they need cause but little anxiety. (3) There is a type of child behavior that is only a symptom of a problem environment. Many of the cases referred to clinics fortunately belong to this last group. Constructive effort to change the environment and give the child a better understanding of his difficulties is invariably helpful in these cases. Examples will be included in the following discussion.

ANGER AND TEMPER TANTRUMS

In considering such aspects of conduct as temper tantrums it is necessary to appreciate fully the different planes upon which moral conduct is enacted in relation to the age of the individual and the stage of social development.⁴ Those who deal with children are concerned very largely with conduct carried out on a low moral plane.

During the early years of life no moral judgments are formed and the child does not think of himself in relation to others. The child is fundamentally selfish and consequently interprets everything in terms of self, his own acts as well as those of others being evaluated by the amount of pleasure or pain they bring to him. He must learn by experience that a certain line of conduct is a paying proposition, so to speak, and that another line of conduct is not; and by "paying" one implies a gain to the child in pleasure and comfort. With proper training and in the proper environment the average child soon learns that conduct carried out in consideration of those

⁴No more practical exposition of this subject has been presented than that of Prof. William MacDougall in his *Social Psychology*.

with whom he comes in contact in his everyday experiences brings him more pleasure and less pain than he would otherwise have. He does not take long to learn that certain experiences are associated with definite pain—for example, touching the hot stove—and ordinarily he can learn in the same way that little or nothing is to be gained by what is commonly called a temper tantrum. Such a tantrum has been described by a parent as follows: "The child lies down on the floor, yells, kicks his heels, and throws his arms about with the intention of inflicting bodily harm on those who come near him."

The tantrum is, of course, purely instinctive and must be met on its first appearance in such a way as to impress on the child not only that nothing will be gained but that such action is positively painful in its results—painful in the sense of bringing a definite loss or of being similar to the experience of putting his hand on the hot stove. This crude and more or less undesirable method of directing and inhibiting conduct during the early years of life should be discarded as soon as possible in favor of appealing to the child's love of approbation, which manifests itself early. Here the attempt is directed toward influencing the child's conduct by appealing to his desire for praise, on the one hand, and his desire to avoid blame, on the other. With children who have reached this stage of development it has been possible to utilize in the clinics a chart system to give the child tangible evidence of the approbation of the doctor, the parents, and others whose praise he most desires.

Temper tantrums, as was said before, are usually physical manifestations of the emotion of anger, which may be stimulated when any of the varied instinctive reactions are thwarted. It is important to know this when attempting to understand the tantrums of the child, because it is necessary to determine the cause of the anger, which many parents say they are unable to account for. It is only after the child, through training and experience, has developed various means of meeting and overcoming his difficulties, that the emotion of anger ceases to be one of the most dangerous stumbling blocks. The instinct of pugnacity, of which anger is the associated emotion, is essential in the development of most successful individuals. It is the driving force to which much of the success in human affairs is due, and it should be controlled rather than stifled, if it is to work to the advantage of the individual.

In every case that involves outbursts of temper it is absolutely essential to study the environment in which the child is being reared, in order to know under what conditions, in what places, and with whom these tantrums are most common. It is of equal importance to make a careful personality study of the child in order to understand as fully as possible the conflicts that he has and the purpose that these emotional upsets serve. It is futile to treat each outbreak by punishing the child or by permitting him to gain some undesirable end. Either method is doomed to failure. Such conduct must be interpreted in terms of the child's experience, if his personality is to be molded so that he will be capable of making a satisfactory social adjustment in later life.

Harriet was first seen in the clinic at the age of 2 years 5 months. The birth had been normal. The patient was breast-fed until 23 months of age.

The mother stated that it was very difficult to wean the patient; she cried so much and went into such temper tantrums that the mother nursed her until 3 months before her next child was born. Teething, walking, and talking all developed normally. She had had none of the children's diseases and had had no injuries or operations.

She refused to go to bed unless accompanied by either her father or her mother. She retired at 8 or 9 p. m. and slept until 8 or 9 a. m. Two or three times during the night she would wake up and scream. Her mother said, "She is probably having temper tantrums in her sleep and is dreaming that she cannot have what she wants." There was no feeding difficulty—she ate everything that was given to her—but there were some indiscretions in diet, such as tea for lunch. Enuresis occurred occasionally. The child had been known to masturbate. Her mother said that the child had a "terrific" temper; that she would lie on the floor and kick and scream on the slightest provocation. When she did not get what she wanted to eat or was crossed at play she developed one of these tantrums. Sometimes they occurred when the mother had no idea what the exciting cause might be. They occurred frequently when she was playing with other children. Following one of these tantrums the child had had "peculiar attacks," getting blue in the face, the mouth remaining partially open, the body becoming stiffened. These spells lasted about 10 minutes. During the 2 weeks preceding the clinic visit she had had seven such attacks.

The policy pursued by the family at that time was one of acquiescence. The patient was said to be generous "when she wants to be"; was jealous; did not want others to have things she could not have; did not get along with other children because she was pugnacious and fought them; was "always very bossy and domineering and always makes other children playing with her do what she wants even if they are twice her size." She was afraid of the dark, would not go to bed without a light; was afraid of animals, especially cats and dogs. At times she had shown marked affection for her father. Her father took no part in disciplining her, and her mother had found that corporal punishment was of little avail.

The father was Italian and the mother was Irish-American. The mother said that the father considered her an idiot and had been brutal to her. She did not know how much he earned. He was very close with his money and gave a dollar a day on which to run the house. He spent little time at home. The mother felt intellectually superior to the father and was always conscious of the racial difference. She said that the father hated their older daughter, Mary, but was devoted to Harriet, whom he fondled and petted. He was also quite indifferent to the baby. They lived on a short, paved street in a three-story brick tenement house. They had a two-room apartment on the first floor. Father, mother, and Harriet slept in a double bed, and Mary slept on the davenport. The mother had furnished the rooms with her own money, and they were fairly comfortable and well kept.

Prior to their marriage the father and mother had lived in Boston as man and wife. At the same time, he was keeping company with another woman. Even at that period he was extremely cruel and abusive to the mother and was very irritable. He would throw cups at her when things he desired were missing at the table. He was arrested in 1918 and was sentenced to jail for 3 months. After his release quarrels were frequent, and in self-defense the mother had scalded and bitten him. Although he was still very rough, showed temper, and drank a great deal, he had not used physical violence of late. The mother knew that he was not true to her and questioned his relations with the patient. There was a story of his having infected the older daughter with gonorrhea when she was 4 years old. His sexual demands were excessive and he masturbated frequently.

At the clinic the patient appeared to be a quiet, demure, neatly dressed little girl, who sat quietly by her mother until she left to enter the examining room. The child then went into a violent tantrum, lying on the floor, kicking her heels, and yelling at the top of her voice. This behavior continued during the half-hour interval while the mother was talking to the physician, but it was not followed by one of her spells. The mother verified the history as given by the social worker and said that the child had been "cranky since the day she was born, always crying and whining." She said, "I could not do a thing with her—she has never slept soundly. I always have to lie down with her and sing her to sleep." Sometimes the patient stayed up until 10 p. m.

and she never had a nap. When the patient got jealous of other children she tried to inflict pain upon them. Whenever her mother paid special attention to other children in the neighborhood or to the patient's sister, she went into a violent temper, bit her sister, pulled her clothes, and tried to bite her mother. Her mother repeated that she was afraid the patient had learned to masturbate from her father.

Treatment.—The problems of enuresis and of establishing routine hours of sleep were attacked first. The mother was instructed to see that the child was put to bed at 6 o'clock and that she remained in bed at least 12 hours. She was warned against all the difficulties that would arise in starting out on this program, but she was told that they would be only temporary and slight compared with the trouble that would occur if the child was not taught to appreciate that tempers could not be used successfully to get her own way. The routine method as described for enuresis was to be followed, and a chart was given to the mother for the purpose of keeping a record rather than to interest the child.

At the end of 2 weeks the mother returned to the clinic, stating that she had instituted the 12-hour sleeping regime but found it impossible to carry out the measures suggested for breaking the habit of enuresis.

The situation was particularly difficult because the child cried violently, the tenant downstairs threatened to have the family put out, and other neighbors became irritated. The father told the mother that she had no brains—what could she expect of the child? He said that he thought coming to the clinic was a waste of time. Under such conditions it was too much to expect the cooperation necessary for improvement. Jealousy and pugnacity continued, and the patient, on one occasion after her last visit, had had a violent temper tantrum on the street. The mother stated that to her knowledge the child had not masturbated since the last visit, and she was encouraged by the improvement which followed the routine hours of sleep.

Comment.—This case illustrates one of the difficulties of instituting treatment that may cause more or less temporary annoyance, not only to the family but to the neighbors. It is not to be expected that a mother will get up two or three times a night to awaken a child, if she knows that such a disturbance of the child's sleep will be followed by a violent temper tantrum and by threats and insults from her husband and the neighbors.

It is hoped that the time is not far distant when facilities will be afforded for taking such children out of the home and training them, temporarily at least, under more favorable conditions.

Isabel, aged 2 years 8 months; birth and development history negative. She had always enjoyed good health; slept well; had well-established toilet habits; had a poor appetite and was very finicky about food. Her mother always had to supervise her feeding, and she refused to eat cereal, eggs, or oatmeal, but was very fond of meat.

The child spent much time sucking her fingers, especially when moody. She was active and interested in outdoor activities. She enjoyed being with other children in spite of the fact that it was difficult for her to get along with them. Only on unusual occasions did she have an opportunity to play with children other than her younger sister. When the opportunity arose to play with other children during vacation periods in the summer months, she met every unpleasant situation by developing a violent temper tantrum. She was domineering and always wanted to be the boss. She was considered a fighter and was rough and pugnacious toward smaller children. She whined constantly, and it was frequently difficult to determine just what she wanted. She would lie on the floor and kick and yell, and was extremely irritable and impatient. After getting the object for which she had tenaciously fought, she would throw it away immediately. She was very destructive. Her fear of the dark developed after the following incident. While her father was playing with her she ran into a dark closet, and her father stood outside the door making a noise like a cat. She seemed to enjoy it at the time and asked him to continue. Since this incident, however, she had refused to go to bed unless the door was left open. In spite of her apparent lack of affection, she made heavy demands upon her mother's time and wanted to be constantly by her side. She rarely showed any affection for either parent and utilized kisses only to get out of some situation that was apt to be followed by punishment. She was rough with animals

but not cruel. She was ordinarily kind and generous toward the baby in the household but at times was rough and pushed and slapped her. Her mother admitted that she did not give much time or affection to the child and said, "I am not naturally affectionate, and my husband is more interested in the children." The mother was of average intelligence and appeared interested, but one felt that this interest was rather superficial and that one of her fundamental characteristics was to take the path of least resistance. For example, she met the finger-sucking problem by giving the child a bottle.

Comment.—The outstanding features in the foregoing case were the unaffectionate attitude of the mother toward the child and the indifference the child showed for the parents. The child's negativistic attitude toward life stood out very prominently. She was always on the opposite side. In other words, she belonged to a group of children who, between the ages of 3 and 5, develop what may be termed "contrasuggestibility."

This condition in children usually lasts but a short time and passes without leaving any undesirable effects upon the personality. On the other hand, there are many individuals in adult life who are chronically negativistic, who are immediately prompted by any suggestion from an outside source to take the opposite side of the question presented. Many of these individuals develop unusual ways. Their habits of living, of dress, and of eating are all such as openly to defy custom and tradition. In children this negativistic attitude toward sleep and general conduct is often difficult to explain, but frequently it represents an effort to attract attention and to keep themselves in the limelight and hear themselves discussed. Invariably these negativistic children are pointed out by the parents as "simply impossible youngsters."

It seems wise, when this negativistic attitude is first recognized, to minimize it so far as possible, to see that the child gains nothing by such reactions but rather that they work out to his loss. Above all, the apparent peculiarity of the child should never be discussed in his presence. This is one of the situations in which the child must be led and not pushed.

This case brings out the importance of allowing children to associate with others of their own age. One of the most fundamental and important instinctive forces is that which is commonly termed the herd instinct. Very early in life the child is capable of benefiting greatly by association with other children. He thus has an opportunity of seeing his own acts mirrored in the reactions of those of his own age and is able to get a better understanding and develop a more sympathetic attitude toward others by virtue of this understanding. It is, therefore, not surprising to find that the child who has been confined to his own household 9 or 10 months in the year, making contacts only with those in the family, experiences great difficulty in understanding and getting along with others when the opportunity arises. In these days, when the hazard of automobile accidents in crowded, congested districts cannot be ignored but must be considered by every interested parent, the nursery and the nursery school afford the desirable opportunities for youngsters to get together. In the performance of their simple tasks, in their play life, and in the educational training received, they will learn much concerning the problems of everyday life as they are related to the group rather than to the individual.

Although not yet 3 years of age, this child was rapidly developing into a cold, calculating, unaffectionate individual who utilized pretense of affection toward others only to gain her own ends. This attitude, of course, only reflected that of the parents toward the child, and it is not surprising that she utilized such asocial reactions as temper tantrums and negativism to keep from being obliterated from the family horizon.

The treatment in this case dealt primarily with the mother. She manifested more interest than the foregoing history would indicate that she was capable of; and as she was of an intelligence above the average, the situation seemed quite hopeful. The treatment of such a case must continue over a period of several months. Much can be expected when this child enters the nursery school in the fall and makes daily contacts with other children. Much has already been accomplished by presenting to the mother the program to be followed, and by changing her attitude toward the patient as much as possible.

Anger is the child's emotional response to a situation in which his demands are not satisfied and he is being thwarted in his efforts to attain some particular end. It is an expression of resentment toward barriers and restraints set up by his environment. It is evidence of

dissatisfaction and may be of value in leading to greater effort to attain the goal, if it does not confuse and dominate him. Anger is not an emotion to be eradicated by drastic methods but one which the child should learn to control. Any normal child or adult will be confronted with many situations in life in which any other emotion than anger would be entirely inappropriate. Indignation is a controlled form of anger and has been the driving force behind many a movement that has benefited mankind.

The child must learn, as he develops, that uncontrolled anger is invariably a handicap in that it results in confusion of thought and action, thus defeating the ends for which he is striving. Rigid discipline which depends upon force and fear for its success may prevent for the moment any expression of anger on the part of the subdued child, but external influences are of little use in teaching the child control of a normal and often useful emotion.

It is the expression of anger resulting from the constant conflict between the child and his environment which should cause concern. This is an indication that for one reason or another the emotional needs of the child are not finding adequate outlets and that he is not capable of making the compromises which are essential under such conditions. Such a child is unhappy, critical, and intolerant, and his pugnacious tendencies get him into all kinds of social difficulties.

There is no better way of teaching a child self-control than by example. Parents who are habitually quick-tempered, who lose control of themselves on the slightest provocation and are always shouting at their children, are obviously setting a bad example. Even if the child, through fear, is submissive in the home, he is likely to compensate for his pent-up resentment in his contacts with other children, especially those whom he can dominate through fear and bullying.

John, 2½ years old, was sent to the clinic from the nursery school with the following statement: "He has a bad temper, is always fighting, strikes and slaps other children without provocation, and always wants what his brother has and fights for it."

In the attempt to determine the cause of this exaggerated pugnacity, rather contradictory statements were encountered regarding the patient's older brother, Henry, aged 4. The home life of the two youngsters was said to be very unhappy and chaotic. The mother and father were always fighting, and both were said to be impulsive and quick-tempered. The father had been arrested for assault and battery, and on her first visit to the clinic the mother bore evidences of his cruelty in the shape of scars.

It appeared that John had always been "mother's boy" and his older brother, Henry, had been the father's favorite. From the nursery school it was learned that the older brother was very sensitive and extremely quiet, that he was absolutely obedient and more polite than other children. At times he was troubled with enuresis and stammering. The mother's story, however, was quite different. She claimed that Henry was bossy and domineering, always wanted his own way, was jealous of the younger brother, had a violent temper, and sometimes bit other children when he was angry. She further stated that he had an intense fear of her, that when she "exploded in anger" or threatened to punish him "his legs actually shook."

When the mother's attention was drawn to the discrepancy in the descriptions of Henry's personality she said that the picture which she had given the previous week "was only true when he was having ill turns" and that usually he was extremely timid and never asserted his own rights, that John would "knock him down and walk all over him and Henry never made any resistance whatever." He was extremely affectionate and liked to be petted and he was afraid of the dark, where he "saw things and people."

In the examining room the child seemed very quiet. He had a marked flush and breathed through his mouth because of a profuse discharge of mucus from both nostrils. The cervical glands were enlarged, especially on the left side; and the adenoids and tonsils were enlarged. The lad was underdeveloped and poorly nourished. He was immediately referred to the medical clinic, and the mother was requested to return to the habit clinic at the end of 10 days.

Careful social investigation revealed the following facts: The father and mother were "always scrapping," and on several occasions the father had been arrested for assault and battery. They were living with the maternal grandmother because the father did not support or provide for the mother. The grandmother reported that there were two distinct factions in the household. The younger child, pugnacious John, was lined up with the mother against the father and timid Henry. Because of the father's work during the day and his pursuit of pleasure at night he spent little time at home. Consequently Henry was left alone pretty much to fight his own battles. The mother had at all times been the protector of John, who had learned from experience that he could tease and torment his older brother without fear of retaliation when his mother was about. Henry undoubtedly had learned that it was the better part of valor to submit to tormenting by his brother rather than to raise his mother's wrath. So day by day the younger lad had become more domineering and pugnacious while the older boy had become more subdued and submissive, only occasionally turning upon his brother and biting and scratching in a crude, instinctive way at such times. This was not mere speculation but was borne out by the fact that John had improved rapidly since entering the school, where he had less opportunity of manifesting his arrogant, domineering ways without punishment. Henry, on the other hand, had retained his shy and diffident manner.

Comment.—The two important points brought out in this case are: (1) The effect of environment on the development of personality and (2) the importance of certain types of symptoms in making a prognosis. A question that is constantly brought up is: If environment is such a tremendous factor in the development of personality, why is it that two individuals coming from the same environment should be so diametrically opposite in character and disposition? This case seems to bring out the fact that it is not the physical environment that counts but the mental atmosphere of the environment. Here were two boys who were born of the same father and mother and reared in the same home, but for whom the mental atmosphere of the home was entirely different. One lived an absolutely sheltered life, basking in the affection of an oversolicitous mother, and the other was living a life of torture, being subjected to the torments of the younger brother and to the persistent reproaches of the mother. It is not difficult to understand why these two children should have developed entirely different personalities, one characterized by a domineering pugnacity and the other by submission and a feeling of inferiority.

With reference to the second point, the prognosis is always discouraging when the individual's personality defect has caused his retreat from contact with humanity. Such a personality defect deprives the individual of the opportunity to develop new interests outside himself. It takes away the necessity of his making an effort at social adjustment and gives him time in which to build, in fancy, life as he would have it. The individual who remains active, keeping in contact with the herd, has ever before him the opportunity of learning life's lessons by experience and by the necessity of adjusting himself to the demands of society.

Katherine was a Negro girl who was brought to the clinic at the age of 2 years 9 months. Birth and developmental history were quite normal. She had always had good health except for measles and bronchitis when she was 2 years old.

Her habits regarding food had given considerable trouble. Until the beginning of the second year she always had to be coaxed; had to be forced to eat at times; was very finicky about carrots, spinach, and other vegetables. Mother "persuaded" her by "showing her the strap." She ate plentifully of what she wanted. Her toilet habits had been established. The patient was very kindly disposed toward everybody and got acquainted easily with strangers, both children and adults. She had shown a tendency to be cruel. She would punch the other children and at the clinic she would frequently knock

them down when they crossed her path. She had a very quick, violent temper and got angry when thwarted. She was extremely jealous of her younger sister because her father would tell her he loved the baby better. When scolded or humiliated she put her fingers in her mouth to keep from crying, and before going to sleep she always indulged in a period of thumb sucking. The mother had kept the child in the house most of the time on account of her marked pugnacity and the difficulty that she caused with the neighborhood children.

At the clinic she was extremely active and mischievous, teasing her mother by pulling at her dress and then running away, pulling down the curtain, and doing numerous other things for which the mother was constantly reprimanding her. She was openly rebellious toward any discipline and defied the mother when any effort was made to thwart her. Instead of crying or whining for what she wanted, she pushed and fought her way until she got it. When attempts were made by the mother to punish her she ran away, dodging and ducking into the corners and under the table, and when finally captured and punished by the mother, she showed no resentment whatever. After she was completely exhausted she went to the corner, sat down, and began sucking her right thumb and twisting her curly black hair between the fingers of her left hand, apparently perfectly happy and contented.

The psychologist stated that it was impossible to get any measurement of the child's intellectual equipment, as she was too active and unruly. She consented to look at one of the pictures presented to her, but her interest lasted only a moment. She appeared to be a bright, hyperactive child who demanded her own way at all times, expressed her ideas clearly in sentences, and played with the pencil and paper. She was interested in everything that was going on; showed marked curiosity and, when opposed, did not hesitate to scratch, bite, and kick.

The patient's father was a hard-working man earning an adequate salary and enjoying good health. The mother was also in good health and had a fair intellectual equipment, having gone through the seventh grade in school. Since coming to this country from the West Indies she had gone to trade school and learned dressmaking. She had worked as a housemaid and in a laundry. She was much interested in her children but was not particularly cooperative so far as the clinic was concerned.

Summary.—We were dealing with a child, not yet 3 years of age, having a normal mentality and coming from a home that presented no outstanding defects of physical surroundings or social relationships. The most prominent characteristics in the mental life of the youngster were her curiosity and tendency to investigate, and a marked hyperactivity and restlessness displayed both at home and at the clinic. Much of the pugnacity which had been attributed to the child seemed to be due to her desire for action rather than to any desire to cause pain to others. Under existing conditions the mother had felt obliged to limit the field of activities to their four-room apartment, which was quite inadequate to meet the demands of the child. It seemed that much of her mischievousness and naughtiness, so-called, could be attributed to her desire for play life and that it was not associated with any unpleasant emotional reaction. To defy and be rebellious was her method of stimulating her mother to activity. Her motive was to be chased and to be given the opportunity of romping and running. One might well expect that when the child enters a nursery school in the fall and is given an opportunity to express herself in group games and rhythmic dances accompanied by music most of her difficulties will be adjusted.

It is always important to study carefully the motives for acts rather than the acts themselves.

DESTRUCTIVENESS

Much of the activity of the preschool child that is termed destructiveness is brought about by the attempt to satisfy curiosity. The child learns by handling, pulling, pushing, twisting, throwing, taking things apart, and exerting his own influence on his surroundings, limited as it may be. During this process of investigation at a time when the child's motor coordination is not well established, it is not surprising that he frequently miscalculates not only his strength

but also the value of some of the material things with which he comes in contact. The wise parent and the intelligent child soon work out some plan which reduces damage to a minimum. Needless to say, this plan must be started early and discipline must be enforced. It must be remembered, however, that the child does not discriminate between what is valuable and what is not. For that reason the child should not be surrounded with breakable things that are expensive to replace, but should be taught to regard with proper respect the material things with which he comes in contact. There cannot be one standard for the nursery and another for the living room. If the child is taught to be careful of the linoleum on the kitchen floor he will have respect for the parlor rug. If he puts a value on his heavy china mug he will be likely to handle delicate china in the same way.

Whenever possible, the child should have some private place for himself, whether it is a room of his own or merely a corner set aside for his use. This should be a place in which he can ramble about without undue restrictions and without fear of doing something that will bring him into conflict with the adult members of the household. The continuous nagging and scolding to which many active youngsters are subjected are the cause of much emotional tension on the part of the child and continued irritation on the part of the parent. The constant fear that something is going to happen if Tom and Mary do not stop whatever they are doing, creates a bad atmosphere in which to rear a child.

Destructiveness may be a way of getting attention, the result of jealousy, a method of getting revenge, or a means of settling a grudge. Under such conditions the child is not conscious of the motive back of the conduct; and only after careful study of the child and his environment, including the personalities and experiences he encounters, is it possible to be helpful in solving the problem.

Lydia was a very attractive little girl, 10 years of age, whose medical history presented nothing worthy of note. She was in the fourth grade in school and getting on well.

She was brought to the clinic by her father, who stated that she was "viciously destructive" and "willfully stubborn." He gave the following details concerning recent happenings.

All during the winter she had persisted in going down into the cellar and turning on the cold water, permitting it to run into the steam boiler. For this she was severely scolded, threatened, and spanked, and finally her bare hands were placed in the hot furnace so that they were badly blistered and had to be bandaged for several days. Fifteen minutes after the removal of the bandages the act for which she had been punished was repeated.

Four days previous to visiting the clinic she scratched the piano with a pin. This episode was followed the next day by the mutilation of the top of the dining-room table with the cover of a tin can. For these two offenses the father scratched her arm and the palm of her right hand with a pin, leaving ugly-looking wounds which were much in evidence when the child was seen at the clinic.

Recently her father had missed several phonograph records and upon being appealed to the patient admitted taking them to school but did not return them, although her father requested her to do so. She said she had given the records to her teacher, but the father went to the school and saw both the teacher and the principal and found that the child had lied. She admitted this later. She was severely switched about the legs on the way home from school, but she maintained a sullen silence until the next day, when she told the housekeeper that she had put the records down through the cracks in the veranda. A carpenter was called and several boards were removed, but no

records were found. A few days later, of her own accord, she produced the records, which had been hidden away in her room.

She wrote on the wallpaper, hammered the walls, and destroyed furniture.

She was the oldest of five children whose mother had died 3 years before the clinic visit. Her father stated, "I have had 20 housekeepers since then." The one in charge then was 63 years old; she was kindly and affectionate toward the patient, and the child was fond of her. The father was a stern, reserved, quick-tempered man who was trying hard to keep his family together, and in spite of his apparent brutality he wanted to do what was right.

At school the patient was considered bright, well-behaved, and truthful. At home she was untruthful, disobedient, destructive, selfish, jealous of material things, unaffectionate, stubborn, and resentful. Her father said, "She is willing to undergo any pain to aggravate me."

At the clinic Lydia appeared to be a happy, cheerful little girl, who frankly admitted her jealousy of her younger sister. She gleefully told about school-day experiences but suddenly became sad and tearful at the mention of her mother. She had apparently assumed the responsibility for "all the rest of the kids," as she called them. She was interested in her schoolmates. She wanted pretty clothes and liked her teachers, the housekeeper, and her father. She showed no resentment at the severe punishment she had received and offered no excuses or explanations for her misconduct. She seemed to be very friendly and approachable. One felt that a sympathetic relationship had been established which would do much to get things going right.

The father was given to understand that punishment was useless, a fact that he had appreciated for some time. He was asked to get on a more companionable basis with the children, and one Saturday he demonstrated his good intentions by bringing three of the children to the clinic en route to the movies. The father's report at this second visit was encouraging. Lydia had been "getting along fine" for a week, none of the destructive tendencies being in evidence. She had seemed happier and more cheerful, had talked more freely, and had been much overjoyed at the prospect of going to the movies.

After the picture show the child returned home. Everything seemed to be progressing well when suddenly, for no apparent reason, she gathered up several phonograph records and destroyed them. There seemed to be no particular emotion attached to this episode, it being apparently the result of an impulsive idea. She was not punished on this occasion, and everything went along smoothly for 48 hours, her father being still hopeful that another week might pass without further manifestation of her destructive tendencies. One evening he brought home a new pair of white shoes for her, a present for which she had shown a strong desire for some time. She was happy over the gift, but within an hour after her father's return she cut the upholstery on one of the best chairs in the living room with a pair of scissors. This information was reported to the clinic by the father over the telephone. He admitted that he had reached the limit of his patience and said that some plan must be made to take the child from the home.

Arrangements were made with a child-study home in Boston to take this child for an indefinite period; but although the father had demanded that such a plan be made, he let the matter drop at that point.

Nothing else was heard about the case until 6 weeks later, when the Society for the Prevention of Cruelty to Children was notified that the neighbors had been much disturbed the previous night by screams coming from the home of the patient. Upon investigation they found that the father had been whipping one of the younger boys severely. They threatened to break in, and the father explained that the boy had been damaging the furniture in much the same way as Lydia had done. The father admitted that he had a violent temper and sometimes lost control of it. It was generally agreed by those interested that the children ought to be placed out, but the father would not consent.

However, a plan was agreed upon and carried out whereby the children would be sent to Maine for the summer months. Such a plan was, of course, only temporary.

Comment.—This child was not under the personal observation of the author long enough to enable him to formulate any definite ideas of the underlying cause of the child's destructiveness. There were, however, several pertinent factors in the history that gave an inkling of the line of treatment that must be followed. The first and most important was the child's devotion to her mother, her inability to assimilate into her own life the situation caused by the

mother's death, and her bitterness and resentment on being deprived of her mother.

In a superficial examination of the facts presented it was found that all the destructive tendencies of this patient were directed toward the house in which she lived and the furniture in it. At school, when visiting, or under any circumstances or conditions not found in her own home, she never manifested any of these destructive tendencies. It seemed that it was the association with her own home that brought out all her vicious tendencies. One also found from the history that for many years prior to the death of the mother the sole interest of both parents had been to save enough money to build a house that would be more or less of a show place in their community, a small unattractive village in the suburbs of Boston. Both parents had worked without daily recreation or vacations and had even gone without the necessities of life, until the death of the mother, in order that another dollar might be put away. It was only after the death of the mother, however, that the father finally erected the \$16,000 house, which stood as a monument to his ambition and thrift. But somehow one could only feel that to the patient, consciously or perhaps unconsciously, it was but a memorial to the toil and sacrifice of the mother for whom she had always shown a very strong attachment. This may be considered merely speculative, considering the little opportunity the writer had to observe this particular case, but it was not unreasonable to expect to find an explanation for these apparently voluntary vicious acts of destructiveness in some deep-seated mental conflict with which the child was blindly struggling.

Martin, aged 4 years 8 months; birth and development normal. He was nursed by his mother for 3 months. From that time on he presented a difficult feeding problem. When his mother's milk gave out, he refused to take the bottle and had a great deal of nutritional disturbance during his first 2 years. He had been a restless sleeper until recently, but lately he had been going to bed at 7 p. m. and sleeping well until morning. Occasionally he had terrifying dreams, during which he had typical night terrors. There were very apt to follow some definite incident, such as being frightened as he had recently been by one of the neighbors, who told him of the bogeyman. He ate well. There was no history of enuresis or masturbation.

The general health of the patient had not been particularly satisfactory. Besides having severe nutritional disturbance during the first 2 years of his life, he had had several convulsions, the first occurring at the thirteenth month and others at intervals of about 6 months. The last one, which had occurred while he was at the hospital, was reported as being definitely epileptoid in character and lasted 30 minutes.

The patient found it difficult to get along with other children. He was unduly pugnacious; he got into many fights and was constantly teasing those with whom he came in contact. He seemed to enjoy playing with animals, but usually ended by using various methods of tormenting them. He was extremely stubborn. His mother stated that when he was told to do a thing he always did just the opposite. She felt that she could not trust him a minute. If she was in the bedroom while he was in the kitchen he would turn on the water faucet or the gas. He had knocked the parlor lamp off the table and had shown other destructive tendencies. If taken into a store he would pick up things and handle them, perhaps grabbing an apple and biting into it. Recently, while at a rest camp, he climbed into an automobile and started it. On two other occasions he had started automobiles on the street. For these reasons the mother lived in fear of what was going to happen next.

When rebuked he retaliated by using obscene and profane language. Recently, when his Sunday-school teacher, thinking he was too young to read, did not give him a Sunday-school paper, he stamped his feet, kicked her, and called her a nasty name. This habit had been growing steadily worse for the last few months. Efforts at home to discipline the child had been fruitless. The mother stated, "He is just one of them kids that is just smart. It's his disposition to be that way, and he can't help it." She further commented that in spite of his sauciness he usually said things with a twinkle in his eye, and everybody liked him.

He had always been extremely active and destructive; lost no opportunity to get into a fight; seemed lacking in any appreciation of the rights of others; would enter any of the neighboring houses without knocking, and openly

appropriated what he desired. At the nursery school he was considered a difficult child to teach, seemed unable to follow directions, and had no sense of rhythm or order. He did very poor work and would not obey—was considered a general nuisance. Of late he had been calling his teacher bad names whenever she asked him to do anything.

The family occupied a four-room apartment situated on a busy thoroughfare. The house was well furnished and homelike, well ventilated and neatly kept. Family relationships were unusually pleasant. Both the father and the mother were much interested in the children and were eager to cooperate in any way possible. The discipline had been left very largely to the mother, who looked upon the patient's behavior as something inevitable and thought that it was too much to expect results from the clinic.

Summary.—The patient, nearly 5 years of age, had been having convulsions at rather infrequent intervals for 4 years. It was evident from his general reactions to the problems of everyday life and his behavior in school that he was not endowed with a normal intellectual equipment or that if he had such an endowment at birth, its development had been retarded by the convulsions. In spite of the fact that the home situation was at least average and the parents were cooperative, it was perhaps useless to hope that satisfactory results would be obtained so long as treatment was carried on in the home, where the mother was inclined to take the stand that "what is to be will be." There was every reason to believe that this child would be much benefited by institutional life during the developmental period, for not only was the youngster's mental development somewhat retarded but the whole situation was complicated by the convulsive phenomena and the emotional instability. Under these conditions a very special environment, such as can be obtained only in the best institutions, was needed so that the limited abilities of the child could be developed to their fullest extent.

DELINQUENCY

The self-regarding sentiment of most individuals is to a very large extent dependent upon the opinion that other people have of them. It is only after an individual has achieved success and established himself firmly in science, business, or a profession that he has sufficient confidence in his own achievements to ignore the opinions of others to any marked degree.

During the early years of a child's life, when imitation and suggestion play a leading part, it is particularly important that he should not absorb from those about him ideas in regard to his own qualities which might react disadvantageously on his conduct. The child who is continually led to believe that his word cannot be depended upon or that he has no regard for other people's property and other people's rights, is quite apt to accept this suggestion as representing the truth and to make no effort to avoid doing what he feels is expected of him. On the other hand, suggestions that he has certain capabilities and that a certain moral standard is expected of him may do much to stimulate his efforts in the direction of a line of conduct which will furnish in itself the satisfaction to assure its continuance. It is too much to expect that the child who is being reared in an environment where truth and honesty are held lightly will develop of his own accord standards acceptable to society. No one expresses any particular amazement over the fact that a child brought up in a German family learns to speak German or that the French child learns to speak French, but we sometime fail to appreciate the fact that conduct as well as speech is to a very large extent an imitative phenomenon.

One mother brought her child to the clinic, stating quite frankly that the child, aged 3 years, used the same swear words that her hus-

band used and that he manifested the same arrogant, defiant attitude toward her that he saw in his father. There is nothing obscure between cause and effect in this particular case. Another woman brought in her youngster, quite perturbed because the child had bought candy with a nickel which had been given her for carfare to visit the dentist. Only a week before, however, this same mother had told the child that she was going on an automobile ride and then had taken her to the dentist. One finds that a child is quite capable at a very early age of differentiating fact from fancy and that one of the first important needs in the development of honesty and integrity is conduct on the part of those with whom the child comes in daily contact which he can safely imitate.

However, the problem is not by any means one of suggestion and imitation entirely, and frequently very complicated situations arise which do not permit such a simple interpretation. A little girl was sent to the clinic by the court because of stealing. Investigation showed that the motive in this particular case was intense jealousy of her chum, whose family could afford to give her many of the little niceties which young girls crave but which the patient could not have. This feeling of jealousy had persisted over a period of years, and it was not until she was given charge of the cloakroom at school, a privilege assigned to her because of her apparent honesty, that the jealousy made itself manifest in stealing.

Delinquent behavior—that is, the type of activity which is eventually going to bring the child into conflict with society—should receive the same consideration and thorough investigation as any other symptom of maladjustment. The only approach to the problem that will bear fruitful results is interpretation of the child's difficulty in terms of his past experience, his present environmental situation, the personalities surrounding him, and his own intellectual, physical, and emotional make-up.

All children who steal cannot be treated in the same way. The child who goes into the department store and steals something which he desires although he has in his pocket a sufficient supply of money to attain the thing desired in a socially accepted way is quite a different problem from the child who steals money to buy candy for distribution among his contemporaries in the hope that he will thus be allowed to participate in their activities.

Stealing in young children often has its origin in what Dr. Healy terms "grudge formation"⁶ and in sex conflicts. Such cases call for most careful, intensive study, frequently over long periods of time. They require patience and kindness on the part of the parents, and before they are satisfactorily adjusted they may tax the skill and ingenuity of the specialist.

The problem of lying also must be regarded from various angles. The lying associated with stealing is invariably of a protective nature and is quite different in its psychological implications from the problem of the child who lies in an effort to bolster up his self-esteem.

Truancy may result from varied motives, some closely tied up with the personality make-up of the child and others entirely dependent upon environmental situations. It is not a sufficient deviation from

⁶ Healy, William, M. D.: *The Individual Delinquent*, p. 376. Little, Brown & Co., Boston, 1915.

normal conduct to be considered too serious in itself. It is only when truancy represents an effort to escape from an undesirable environment that it should cause concern, and then the environment rather than the symptom requires treatment. It is the spirit of "wanderlust" in most youngsters that prompts them to investigate whatever is strange and new. To most youngsters this means nothing more than investigating a new alley, making friends around the corner, or going to the park; with the more venturesome it leads at times to the motion-picture shows or wherever there seems to be anything exciting going on. Unfortunately most of these early truants are punished after the first offense, and the punishment in no way inhibits their desire for future adventure or satisfies the curiosity stimulated by their first experience. It is only when the moment to return home is at hand that they recall the last experience. This very often prompts them to remain away from home on account of fear. One youngster with the habit of remaining out at night with the other boys, who would leave him one by one, said he was always afraid to return home "to face the music." His mother said that he had been beaten very hard but that it did no good. Beatings do not solve these problems.

The discovery of the child's motive—that is, what he hopes to accomplish by his misconduct—is a prerequisite for any intelligent plan of treatment. The importance of this is brought out in the following cases:

Nora, aged 10; birth and developmental history quite normal. She was the third of five children. She was brought to the clinic by her mother because she told "silly lies" without any reason, stayed out at night without permission, and stole small amounts of money. The child had had measles and whooping cough, but none of the other children's diseases; had no history of injuries or operations; slept and ate well, occasionally talking in her sleep but not so as to be understood. She wet the bed at infrequent intervals. The mother said that the child was selfish and always wanted her own way. She was not affectionate and showed no attachment for her father or mother. She was extremely jealous of her younger sister, wanted everything the sister had, and resented the mother's showing any attention to the sister. She was constantly quarreling with other members of the family, and was "irritable and snappish." The mother stated that she did the punishing with a strap, as the father seldom disciplined the child. The patient was apparently afraid of her father but not of her mother. The mother said that the child got along well in school and got good marks, but subsequent investigation did not bear this out.

The following comments on the other children in this family were of interest: George, aged 15, was said to be disagreeable, troublesome, and a trial to his mother. When 8, he was arrested for breaking into the girls' high school with two other boys and destroying microscope lenses. He was put on probation, and his conduct since had been unsatisfactory. Four years later he was again arrested for breaking into and entering a grocery store, but the case was dismissed. He was always lazy at school, which he left at the age of 14, having repeatedly played truant. After leaving school he worked as an errand boy for 6 weeks at a stationery store and made \$7 a week. He was looking for work at the time of the clinic visit and spent most of his time on the street. He was scornful and defiant toward his father, and refused to go to church. Joseph, aged 10, was still attending school. He had always been well behaved until 2 years before, and after that he had become irritable when crossed. He was arrested with two other boys for taking a doctor's kit from an automobile and was put on probation. The two younger children presented nothing abnormal in their physical or mental make-up worthy of note. They had no conduct disorders.

At the clinic the patient appeared to be quiet and subdued. She was rather well developed and well nourished and was fairly attractive. She manifested little interest in her surroundings. When questioned regarding her delin-

quencies she answered quickly but apparently without frankness, judging from the data previously obtained. She accounted for the time spent away from home as being spent with her girl friends and with the other children on the street. She said she never asked permission to go out because her mother always refused it. When she was out, she said, she was afraid to go home. She appreciated the seriousness of her present situation and her attitude toward her difficulties seemed quite normal. She admitted quite frankly that she did not like housework, but said she was willing to do it since she must. She was looking forward to learning cooking in school the next year. She admitted taking money that she found about the house, stating that the amounts varied from 10 to 45 cents and that she always denied having taken the money because she wished to avoid the punishment that always followed. She said she enjoyed most being on the street or with her friends and liked to be away from home. She read little and did not care for the movies.

The following briefly summarizes the home situation. The mother appeared to be a hard-working woman who bore the marks of her toil and hardships. She had never had good health and was obviously discouraged over the discord among the members of the family and the poorness of the tenement in which they had to live. She had always had considerable worry and anxiety over the three older children. Her husband kept her constantly upset because of his marked irritability and fits of temper, which disturbed the family most of the time. He was apparently disgusted with the lack of success they had had in raising the family, and there were many scenes between him and the oldest boy. The husband's reactions were always worse when he had been drinking. The patient seemed to be his favorite child and had considerable influence over him when he was having one of his "spells." The mother tried to adjust to this chaotic situation, but the alcoholism of her husband and the constant quarreling of the children made her very unhappy. The home situation was quite intolerable. The family occupied a five-room flat in a poor neighborhood on a noisy, crowded street. The tenement was damp and cold, and in spite of the mother's efforts to improve it it was not attractive.

During the first clinic visit little was accomplished except to get the history and an interview with the child. The mother was requested to return to the next clinic, but it was several weeks before she appeared again. The report was very discouraging. The child continued to disregard her parents' wishes, paying no attention whatever to her mother. She always avoided telling her mother where she was going and where she had been, even if her conduct had been such as to justify praise. Her school work was not satisfactory, and it was expected that she would have to repeat her grade or else take summer-school work.

On the second visit sufficient time was taken to discuss the problem in some detail with both the mother and the child. It appeared that the mother's restrictions on the girl had been rather severe. Her anxiety over the patient's whereabouts and her distrust of her ability to take care of herself made the mother feel that the only safe place for her was in the house. The family budget was such that the mother felt unable to give the youngster any allowance and she invariably refused her when she asked for money. The mother was frank in admitting that on occasions her irritability toward the other members of the household was spent on Nora, and that she rarely, if ever, had any time to devote to her except for matters of discipline. An effort was made to present to Nora some of the difficulties of the mother's position and the importance of her assuming certain responsibilities in helping out in the household and causing the mother as little anxiety as possible. It was agreed between them that the patient should have an allowance of 10 cents a week and that she would ask her mother's permission before she went out to visit other girls or to play in the street.

The mother did not return until about a month later, notwithstanding the fact that she had been urged to make weekly visits to the clinic. She said that the patient was doing better, and that she was not running away as she formerly had, but that she was still very unreliable about keeping her promises, irritable with the other children, doing poorly in school, and of little assistance in the household. The mother said it was difficult for her to get to the clinic more than once a month because her household duties made heavy demands upon her time. The whole situation was gone over again in detail, and an effort was made to have both the mother and the patient make some concessions.

The following month the mother returned to the clinic. Although she was very reluctant about admitting an improvement, she said that Nora "did not

run away any more, and she did not tell silly lies" so often. She reported that Nora was still very quarrelsome and hard to get along with. Her school work was poor and her deportment mark low. At this visit, the patient got a little friendly and confidential for the first time. She said that although she did not like her teacher and hated the thought of going to school during the summer, she was very anxious to stay in the sixth grade so that she could be with her brother. The child was apparently in a very unhappy frame of mind, resenting authority and feeling that she was not having the opportunity that other children had. Her attitude seemed to be that she had to take whatever she got out of life in spite of what others thought. The mother seemed to feel absolutely hopeless. She had lost her courage to go on, was unable to see anything bright in the future of the patient, and did not hesitate to let the patient know how discouraged and unhappy she was about the outlook.

The patient did not return to the clinic for several months, and then she came alone. She stated that she was getting along well in school, that things were improving at home, and that she was getting more confidence in her mother. But the mother's report, as gathered by the social worker, was that of a harsh, pessimistic critic who saw nothing but the unfavorable side of the situation. She had just received a school report which indicated Nora's absolute failure. Her deportment, writing, and geography were poor, and the mother laid great stress on these failures. Nora said, by way of apology, that besides these poor marks she had received four marks indicating exceptionally good work—a fact that the mother admitted. When the patient was asked in her mother's presence if she was helping in the household, the mother spoke up, saying, "Believe me, she don't do much. She lies and steals money. I don't dare take her in anyone's house for fear she might take something." The mother still refused to give the child money for any purpose, in spite of the promise she had made at the clinic. The patient said that she never had a chance to go to the movies, that she got candy from other children but never had any of her own—"only what I take. The girls I play with sometimes have candy and sometimes give it to me." She thought that a little girl of her age should have 10 or 15 cents a week.

The child was given a long talk on the value of honesty, playing the game fair, and helping her mother. The mother was interviewed at length about the absolute necessity of changing her attitude toward the child. The importance of making the child believe that something was expected of her was called to the mother's attention. It was pointed out that nothing could be accomplished if she persisted in impressing the child with her delinquencies, especially if this was done in front of other people. The fact that she had unsuccessfully followed her own methods with the older children was pointed out to her with extreme frankness, and an effort was made to show her that nothing could be lost if she followed the plan outlined by the clinic.

Notwithstanding the fact that the situation seemed extremely hopeless if the child was to remain in that environment, it seemed worth while to continue the efforts in this case. Something about the patient—her honesty and frankness at the clinic as compared with her reported actions at home and her insight and appreciation of the importance of overcoming her delinquencies—gave encouragement in spite of the wretched environmental conditions in which she was living and the poor cooperation of the mother.

The latest reports from the school had been encouraging. The patient was in the seventh grade, got along much better than the year before, got a mark of "one" in effort and "two" in conduct, and had not been sent to the office for disciplinary reasons during the entire year. The patient was frank and free in her talks with the doctor and had lost much of the stubbornness which characterized her first visit to the clinic. Her mother had put her on an allowance of 10 cents a week and had recently given her 30 cents to go to a festival. There was no trouble at home about taking money, and the patient seemed to be making a fairly good adjustment. She had passed all her examinations in school and was looking for a summer job instead of having to make up school work.

Although this improvement had been in evidence for a period of only 3 months and might not continue without occasional relapses, the case was particularly interesting as an indication of what could be done in spite of wretched environmental conditions and lack of cooperation. Besides the rather infrequent visits to the clinic during which the problem had been discussed with both parents and patient, successful efforts had been made to get

the girl interested in a girls' club and in taking books from the library, both of which activities gave her much-needed interests other than street life.

Olive, aged 6 years 4 months, third of four children—the other children being 8 years, 7 years, and 11 months old, respectively; birth and development normal except that talking was delayed until she was 26 months of age and that she had always lisped. Except for an orthopedic operation on account of a shoulder deformity, the child had always enjoyed good health. Prior to this operation she was very restless at night and frequently walked in her sleep, but since the operation her sleep had been restful and quiet. She had a good appetite and was not finicky. She was said to be domineering and quarrelsome and preferred to be alone, although she was not shy. She was extremely affectionate and sensitive and was inclined to be jealous when she saw others being petted. She got along well at home—at least her mother said the child was easy to manage. She enjoyed her play life and spent much time by herself. Her mother denied that the child had any propensity for stealing (in spite of a history to that effect obtained from outside sources) but admitted having lost money which she had left about the house. She said she could not suspect the children as she had always trusted them. The child was in the first grade. In spite of her history and the poor impression she made during the first contact because of her unattractive manner and unkempt appearance, she graded normal on the psychometric test.

The parents were separated, but the father occasionally came to the house to see the children. The mother seemed quite devoted to the children, and although the living quarters were poor—they consisted of a four-room apartment on the third floor of an extremely dilapidated building—and the home was untidy and cluttered, she attempted to do more than give them purely custodial care. She made an effort to amuse them, occasionally taking them to the motion pictures and for walks.

Olive was referred to the clinic by a settlement worker because of her persistent stealing and the conditions under which the thefts were carried out. From the settlement she had taken two hats and an umbrella. She was frequently found going through the children's clothes, rifling their pockets. She admitted these thefts only under conditions in which it was apparent that she must be caught. Even when called to account for having stolen an article, she would make attempts to take things from the person reprimanding her. It did not matter whether the articles were of particular value or whether they would naturally interest a child of her age. From the school she had taken beads, a rubber ball, a teacher's key, fruit, and numerous other articles. When confronted by one in authority with the charge of thieving, she invariably denied the thefts but always confessed later. There seemed to be no outstanding problems except the stealing and lying.

The home situation was one of filth and immorality. The father had apparently spent much of his time with other women prior to leaving home. He claimed that the mother was irresponsible in the care of the children and the household, that she used vile language, that she never had the meals ready, and that the house was always dirty. She, on the other hand, accused him of having a violent temper, saying that he frequently went into a rage and that there was nothing too mean or vile for him to say. It appeared from the history that both of them had associations of the lowest type.

Obviously little or nothing could be expected by the clinic in the way of co-operation by the parents. The only hope of helping the child lay in those with whom she came in contact outside the home. The assistance of her teacher was solicited, and her cooperation did much toward any improvement that was made. The teacher stated that the patient was a dear little girl; she seemed to be much attached to her. The child got along well with the other children in school, but it was very difficult to make her concentrate. She did not seem to have any interest in school, was poor in all her subjects, and probably would not be promoted. At school her speech defect was a great handicap. She was considered very childish for her age.

At the clinic she entered the examining room in a shy and diffident manner but did not appear frightened or resentful. At first she merely smiled at the examiner's questions. Soon, however, she became more responsive and, with a marked defect in her speech, began to repeat letters and numbers for the doctor.

She volunteered a little information about her home life—the fact that she had two brothers, that her father took her to the movies, and that she went to the beach and to school. On the first visit she was very reticent about discussing delinquencies, and the subject was soon changed to a more pleasant one. She said she liked to play ball and skip rope but did not like dolls because they break; she liked the dances at the movies and said she could dance; she told of seeing Charlie Chaplin, told the doctor what she had had for different meals during the last 24 hours, named a number of common objects in the room, and gradually became more interested in her surroundings.

A week later the patient returned to the clinic. She was much more friendly but still a little shy. She made an effort to carry on a few speech exercises, imitating the doctor. When asked with whom she played she said, "No one." When asked why, she said, "Nobody likes me." Then she discussed the subject more spontaneously, saying that she didn't see why they didn't like her—no one liked her except her father and mother and the baby. Girls didn't like her; they knocked her down. She insisted that she was the only one the other children did not like. She said she didn't like anybody but her family. There seemed to be real emotion attached to the idea that nobody liked her. She tried to hold back the tears, but it was difficult. She talked more frankly about her thefts and tried to justify herself by the fact that she did not like those from whom she took things.

At this time she was given a long talk, in which she took considerable interest, about how she might make people like her, about playing fair and square, and about how she would feel if other people took her things. She was told that a careful record was to be kept of the days on which she did not take things and that she was to bring the record to the doctor the following week. The teacher was seen, and arrangements were made to keep a chart on which a star would indicate each day that the patient's conduct had been satisfactory. This was carefully explained to the patient. She started off in a happier frame of mind than she had thus far exhibited.

Just a week later the following report was received from the school: "Olive has been getting on much better during the last week. It was not until yesterday morning that she was found peeping into the school desks in a rather suspicious way. There is no record of her having taken anything that did not belong to her at school all week." At the clinic, however, she found two pennies in the toilet, which she returned with some reluctance. She seemed quite happy while at the clinic and said she enjoyed making the visits.

The following week the report was excellent. The patient was much pleased at the interest the teacher had taken in her and was apparently making a persistent effort to get the coveted stars to bring to the clinic. At the settlement house which she visited frequently, however, she was found several times in the act of taking things that did not belong to her. Her reaction on being questioned about taking these things seemed one of remorse—she cried and seemed very much upset.

There was something very inaccessible about this child. She chattered away and answered questions very readily, but it was difficult to get close to her innermost life. The last report received from the school was excellent. "Olive has not taken anything for a long time." She came into the clinic cheerful, happy, and cleanly dressed. She had genuine pride in the fact that she had such a good report, and again it was felt that in spite of wretched environmental conditions much had been accomplished toward helping this child to overcome two very asocial reactions and to get much more happiness out of life.

Paul, a lad 13 years of age, was brought to the clinic by his stepmother, an unusually bright, intellectual woman, extremely fond of and interested in her stepson. For the last 5 years he had been developing certain delinquencies that had caused the family much concern. He began by taking money from the family and doing such things as mailing letters without putting on postage and short-changing when sent on errands. He would tell lies to get out of difficult situations. He would not, however, persist in the lies but would confess what he had done and then break down and cry.

About 3 weeks before coming to the clinic his stepmother lost \$5. About the same time the patient came home and said that he had got a job in a store. He gave the name of the store, the man he worked for, and the streets

where he had to deliver goods. He elaborated to the extent of telling what the storekeeper and the customer said to him. He said that he was treated well and was given crackers at the store. At the end of the week he brought home \$5 and turned it over to his mother. Investigation revealed the fact that the lad was not employed and that the money was the same that he had stolen. Immediately after this episode, he made further attempts to take money; that is, he was found searching in places where money was usually kept.

This lad was in the eighth grade and was getting on well in school. The psychometric test showed that he had normal mental equipment. He had never worked. The father was generous to the children; he gave them a dime on Saturday with which to buy candy. Paul was interested in playing football and baseball and in skating and sledding, and got along well with other boys. He said everyone was kind to him. He admitted that he cried easily but knew no reason for doing so. He appeared to be an unusually cheerful, active boy who, in the examining room, was frank and honest. He made no effort to attribute his delinquencies to others. He said he seldom went to movies and never went with a gang.

A study of this case showed that the motive was the desire of the boy to emulate his father and play the part of a grown-up in helping to provide for the family. It was what Kirkpatrick has called "passive enjoyment rather than active effort," but the motive was obviously not a malicious one, and intelligent cooperation on the part of the parents made it quite easy to straighten out this lad's point of view. The social-service department of the clinic was very active in this case. The lad's interests were broadened, and arrangements were made for him to spend the coming summer on a farm. The last notes stated that he had been completely freed from his former delinquencies, that he had been getting on well in school, and that the family had been relieved of the worry and anxiety that were naturally associated with his former difficulties.

Quentin, aged 11 years, was brought to the clinic of the psychopathic hospital by his mother upon the recommendation of the principal of his school. He was under the jurisdiction of the court for entering a hotel by one of the side windows and taking \$10 from a desk. He denied the theft when discovered hiding in a closet, but finally gave the money up when the policeman arrived. He had stolen many car tickets from the family. There had been a long history of delinquencies.

The patient was a keen, bright lad, with normal intellectual equipment. He discussed his trouble frankly and was anxious to overcome his "bad habits." He was kind, affectionate, generous, made friends easily, was interested in all sorts of games and sports, mixed well with other children, and never held grudges. He lacked interest in his studies and up to the time of coming to the clinic had never responded to discipline. He had been scolded, deprived of privileges, and whipped, without results. He had no fear of policemen nor of going to court.

Through the social-service department of the clinic this lad joined a boys' club, and supervision was carried on from the out-patient clinic. Results were extremely gratifying, and the last report of the lad was, "Getting on well."

It is of interest to note that although the parents attributed the lad's delinquencies to an accident which happened about 2 years before, the boy's statement was, "My mother says I do these things because I hurt my head and get crazy, but it is because I want sleds and things. My brother used to do all these things. Now he is big and he gets me to do them." Frequently parents try to attribute the delinquencies of their children to some sickness or accident, and sometimes the children themselves are prone to accept the suggestion as an excuse for doing those things which they enjoy.

Gordon, the older of two children, was referred by his mother to the clinic at the age of 4 years and 9 months for disobedience, masturbation, and quarreling. He was also described as stubborn and very destructive.

Birth was by Cesarean section. Developmental history was normal except that the patient had been given a bottle until he was 2 years of age, having refused to drink milk from a cup. At 4 years he had had whooping cough,

followed by influenza, pneumonia, and an abscessed ear. He had been circumcised. Tonsils and adenoids were removed when he was 2 years of age. His eating habits were always a problem. He refused to eat unless fed, told a story, or offered a reward. He had enuresis until he was 4. Occasionally he bit his nails. He had masturbated since infancy, apparently without realizing it. The patient presented the picture of an undisciplined child, very stubborn and negativistic. He was prone to show off, and was very destructive of furniture and toys. He would throw objects about without any consideration of the possibility of injuring another child.

The home situation was physically good, but was undesirable from the point of view of meeting the patient's personality needs. Maternal relatives in the home dominated the situation, and the mother's attachment and dependence on them showed her own emotional immaturity. The psychological examination revealed the patient to be of normal intelligence. The case was carried in the clinic for 7 months, but service was interrupted by the mother's inability to attend because of illness. The mother lost interest and the case was closed while the boy was still unimproved. The psychiatrist considered the mother's own adjustment very poor. He observed that she seemed unable to profit by advice regarding a better technique for handling the patient's problems.

Two years later the mother referred the patient to the clinic. The same problem appeared as before, with the additional problems of lying and stealing. The previous problems were all intensified. Gordon had no idea of obedience and presented many types of habit difficulties. He was extremely jealous of his younger sister; he had begun to have nocturnal enuresis; he had developed the habit of biting his finger and toe nails; and he chewed his pajamas, blouse collars, and so forth. He took money wherever he could get it and used it for the purchase of guns. His mother threw away the guns, because of her fear that the patient would grow up like "Abe" F——, a man who had been involved in a bank-robbery case and who was well known to the patient's family.

Gordon was very inattentive and a daydreamer; in fact his mother had at times feared he was deaf. His lack of concentration made his teacher in the second grade consider him the "worst child in the class." His first-grade teacher, having had a much smaller class, had had no difficulty with him. Much of his behavior was thought to be a demand for attention.

A new psychological examination gave the patient a rating of good, average intelligence. A hearing test showed a loss of hearing in both ears, but this was not considered sufficient to account for his lack of response.

Home conditions had been somewhat improved, as relatives no longer lived with the family; but the mother was still very dependent on the relatives. She also rebuffed the patient and favored his sister. She had not wanted a boy. The father worked long hours, saw the children seldom, and thought that the problem was the mother.

The problem of stealing was treated by arranging for an allowance to the boy from the parents to take the place of former gifts from the grandfather. Attempts to give the mother a more objective point of view and a knowledge of mental-hygiene principles were not very successful because of her own emotional immaturity. In spite of this, however, the patient's behavior showed some improvement. Arrangements were made for "attitude therapy" for the mother. It was also recommended that the father attempt to give the patient more of his time.

Mildred was 6 years and 8 months of age when first seen at the habit clinic. She had been referred by a school teacher because of lying, stealing, truancy, and swearing. She also had temper tantrums.

Mildred was born of an illegitimate union, and nothing was known of her parents. She had been adopted shortly after birth by Irish parents of a low intellectual, economic, and social level. At the time of the clinic visit the adoptive mother was over 60 years old and the father about 44. The reason for the adoption was the mother's desire to compensate for her inability to have children of her own, since she was past the child-bearing age at the time of her marriage. Besides the patient and the adoptive parents, a maternal aunt was in the home.

The patient's early development was normal and she was in good health. She had had no diseases, operations, or accidents. She had good eating habits

but was a restless sleeper. She had the habit of hiding in bed such stolen articles as scissors, nails, and pencils. She had been masturbating since she was 2 years old.

This child lied about everything. She had stolen candy from the five-and-ten-cent store, and she frequently took things from about the house and hid them. She had started to swear at about the time that she was referred to the clinic.

Her temper tantrums dated back to the age of 17 months. They were resorted to when she could not have her own way. When having such a tantrum, she would scream, kick, pick up anything handy, and threaten her mother with it.

She usually played with younger children, and whenever she become angry with them she would hit them with the first weapon she could find. On several occasions she had hit a neighbor's child on the head with a hammer.

She was hyperactive, stubborn, willful, and quite unaffectionate. She completely dominated her parents, who no longer made any effort to discipline her.

It seemed unlikely that the patient would improve in this environment, as she had complete control of the situation and her parents were too ineffectual and ignorant to profit much from attempts at reeducation. Mildred was accordingly placed for observation in the study home of a child-placing agency with the possibility of long-time placement in a foster home. The clinic, however, was unable to convince the parents of the advisability of such a placement, and the patient returned home.

Intensive therapy was then carried on by the social-service department. For several weeks the patient showed improved behavior and the mother appeared to make an earnest effort to help carry out the clinic's recommendations. The maternal aunt refused to cooperate, however, and the home situation became worse when the patient realized that she was the cause of friction between her mother and her aunt. The case was closed after 7 months, as it seemed useless for the clinic to try further treatment until the home situation should be improved by the aunt's departure from the household or by a change in her attitude.

Truancy, which is a common problem among urban children, may be motivated either by the desire to escape from an unhappy situation or by curiosity about the unknown and longing for something new. As with much undesirable behavior, however, once a pattern is established it seems to become self-perpetuating; and although the original motive may be forgotten, the habit has become so strong that no new motive is necessary.

Sam was a colored boy, 6 years and 10 months of age when first seen at the clinic. There was nothing unusual in his birth or developmental history.

The patient went to bed, when he was at home, at about 9 o'clock and slept until 8. Often he did not come home until after midnight. He sometimes had nocturnal enuresis. His appetite was excellent and he would eat anything. He was quarrelsome, hyperactive, and stubborn. He could not be trusted and he tried to be very independent. He ran away whenever he had a chance and often did not come back until late at night. His family picked him up in police stations and on the streets. According to his mother he had "business ability." He sold newspapers, ran errands, and shined shoes. He either gave the money to his mother or bought food with it. The patient was curious and liked to look at books, but he had a reading disability. He was very imaginative and invented stories. Once he made up a story from the illustrations in a book he was supposedly reading aloud.

This patient had an intelligence quotient of 99.

The family occupied a six-room apartment on the first floor of a tenement house. The apartment had a bathroom and three bedrooms. The furnishings were adequate. Sam slept in a room with two brothers, sharing a bed with one of them.

The problem as presented by the father and mother was that of truancy and difficult behavior. Sam had been a truant off and on ever since he had left kindergarten. He would wander away with the other neighborhood children. The family moved away from the neighborhood and the first Sunday in their new home Sam wandered back to the old district. He might go as far as 5 miles in his wanderings, sometimes riding on the back of a streetcar.

A week before his first visit to the clinic he had left home about 2 p. m. and had been found by the police at 3 a. m. after an 8-hour search. He picked up a dime to a dollar a day from his various activities, such as dancing, singing, or getting papers and selling them. He would often bring home rolls which he had bought. At other times he would bring home money. He was in and out of restaurants, eating until he no longer had an appetite for meals at home. Sometimes larger children took his money from him.

The patient, when interviewed about his truancy, stated, "I sell papers; I work in a barn; I mind the horses and keep people from taking them away; I work in a show—pick up papers so I can get in for nothing. Sometimes I clean automobiles; for a dollar I do the wheels and the windows and clean the seats and everything."

It was suggested that the patient be placed out in the country in order to determine the importance of environment in his conduct. He was placed in a suburb by a child-placing agency and he got along very well. His problems have been minimized and there is no evidence of truancy at present.

RETREAT AS A METHOD OF MEETING FAILURE

Unlike children who develop a resentful, rebellious attitude toward restraint are those who respond by retreat. These children do not battle in an endeavor to break down the barriers but are inclined to retreat in the face of obstacles, to become submissive rather than rebellious. The mental characteristic known as plasticity seems to play an unduly important part in their make-up. They offer no resistance to factors in the environment which play upon them. These children as a rule are timid, shy, and cautious. They find little satisfaction in the activities of their more venturesome companions. Thus, while one child is thrilled by the experience of playing truant from home or school, another finds his satisfaction in the overprotective atmosphere provided by an oversolicitous mother. One lad finds life crowded with so many interesting and exciting episodes that he spends but little time thinking what it is all about. To another child life is dull, barren, and boring. He runs away from it, and only in his daydreaming does he get enough satisfaction to justify his existence. These children are self-centered, critical, jealous; they have limited interests and few friends. They get but little satisfaction from the ordinary, everyday activities of life. They turn their headlights in upon themselves rather than out upon the world. They are inclined to be extremely dependent on one or two people but are quite withdrawn from the world at large. Many of these children in early life are looked upon as being resourceful, capable of entertaining themselves and providing their own amusements. This in itself is of value if it is not just part of the activity of an asocial child.

These children invariably suffer from a sense of inferiority. They do not enjoy any feeling of security about life, and in comparing themselves with other children they are vaguely conscious of their own inadequacies so that they seek to avoid competition when failure seems inevitable. The importance of preventing the child from developing what is commonly known as an inferiority complex is apparent to all who are concerned about his happiness and efficiency. The child is so dependent upon the opinions of others, especially those from whom he seeks approbation, that adults cannot be too careful about helping him to build up his self-esteem. A father who thoughtlessly tries to stimulate his boy to greater effort by constant teasing may be quite unaware that this humiliates the child and does something to his pride that will not easily be eradicated.

When the standards set for the child, whether in conduct or in school work, are so high that failure is the rule rather than the exception, the child is losing the one great motivating force to further effort—success. Children who are unfavorably compared with others in the home or neighborhood develop a sense of inferiority very easily, especially when the comparison is unfair because of their inherent deficiencies in mental equipment or physical strength. Habits like enuresis and masturbation, when managed unwisely by the parents,

may also cause the children to feel that they are different, leading them eventually to build their lives around their liabilities instead of around their assets.

Of course, mental and physical handicaps necessarily impose certain limitations upon a child, but even when these are present every effort should be made to see that the child has an opportunity to develop to the fullest extent of his capacity. The child who is conscious of doing this will not feel inferior.

When the child, no matter what the reason, develops this feeling of inferiority, many things may happen. As has been shown, some children bolster up their self-esteem by aggressive measures such as stealing, truancy, and defiance toward authority. Others assume the protective attitude of always being right while everybody else is wrong. But the group we are concerned with at the moment succumb to their feelings and take the passive course which appears to them to be easier. Shyness is a mode of behavior that serves as a retreat for individuals of all ages, but the emotional experience leading to this behavior is often obscure. In the following case shyness was associated with stammering and both conditions seemed to bear a definite causal relation to an unhappy home situation to which the child had been unable to make a satisfactory adjustment.

Adele, a Negro girl, 4 years and 9 months old, was referred to the clinic because of shyness.

Birth and development were normal. She had had chickenpox, measles, whooping cough, mumps, and sore throats. Her habits were regular.

Adele was a shy, quiet, unassertive child who did not appear to be interested in her environment. She asked few questions, being content to sit back and watch what was going on. When speaking, her voice was scarcely above a whisper. Although quite able to take care of her own wants, she was never very active or noisy and spoke only when necessary. Her shyness had been apparent at so early an age that her mother thought it must have been inherited. At times the child stammered considerably, according to the mother, although the school and the clinic saw no indications of this. In kindergarten the patient did good work, but she talked little and never made advances to the other children of her own accord. Aside from kindergarten she had little or no contacts, for the mother treated her as a "hothouse flower" and considered her too delicate to play outdoors except in very pleasant weather.

When tested at the clinic the child showed normal intelligence; her intelligence quotient was 105. As usual, she was shy and bashful.

There was considerable friction at home. The father was cruel and abusive to his wife and was interested in other women. He paid no attention to the children. The mother had no social outlets. There were, moreover, religious differences between the parents. All this resulted in many bitter quarrels in the presence of the children.

Careful study of this case showed that after one of the parents' quarrels the child's stammering increased noticeably and her withdrawal became more apparent. The mother was urged to allow the child to play outdoors without too much supervision from herself and to encourage the child's social contacts. Arrangements were made to have the mother and the children attend a camp. The harm of overprotection and the results of marital difficulties as they related to the child's problem were discussed. The mother tried to cooperate with the clinic as far as she could, and the child developed more independence.

In the following case shyness was associated with general timidity.

Pauline was referred to the clinic at the age of 5 years and 9 months because of her extreme shyness. She was also described as oversensitive and timid and given to crying easily.

This child's birth had been difficult (breech presentation) but her development was normal. She had been in good health until her fourth year and then within 1 year she had measles, whooping cough, and mastoiditis. She recovered from all these infections. She wore arch supports to correct flat feet,

but suffered from no other defects. Her eating, sleeping, and toilet habits were normal.

Her mother described her as being very shy and as having a tendency to be unduly anxious and worried over minor matters. When she was with other people she was likely to hang her head and seem embarrassed, especially in large groups and in school.

These traits were demonstrated at the clinic. In the clinic playroom the child stayed close to her mother and was very reluctant to join the other children. She was overconscientious about the order of the toys, chairs, and other equipment in the room.

The parents were intelligent and the home atmosphere was harmonious in spite of financial strain. There were two other children, who seemed entirely normal. A sister of the patient had died during the preceding winter and this experience had a serious effect on her. She was sensitive to her mother's grief over this loss and would try to comfort her. At the same time she was apparently having reactions of her own to this experience as well as to the family financial difficulties. Her mother observed that she seemed to be "walking in a trance."

In the psychological examination this child proved to be of good intelligence, having an intelligence quotient of 113.

In the absence of either physical or mental handicap, treatment was directed toward increased socialization of the child and a change in the family methods of discipline. The mother cooperated well with the clinic. She not only allowed the child to play more freely with other children, but she restrained herself in the use of peremptory commands and in her constant emphasis on cleanliness and manners. In the more relaxed atmosphere the child soon lost some of her tenseness and no longer found it necessary to hide behind a wall of shyness.

The death of some member of the family is often the source of behavior difficulty in a child—not that death in itself is a cause of behavior problems but that members of the family are often unwise in their explanation of it or in the display of their own emotions and attitudes.

The following case is interesting in its presentation of an unusually complex method used by a 4-year-old child to escape the mental anguish associated with the death of his grandmother. It also indicates that even at this early age the child meets his problem quite differently in relation to different individuals. The symptoms in this case were such as to cause real anxiety, for the child's regression from reality into a world of fantasy seemed complete at times. However, responses of this type to difficult life situations are not particularly uncommon in children. Although every effort should be made to so organize the child's mental outlook on life that he may become more objective and deal more efficiently with reality, the implications of such symptoms during the preschool years are quite different and of less significance in relation to actual mental disease than would be the case in a preadolescent child.

A mother brought a lad of 4 years to the clinic because of persistent masturbation and stubbornness. An analysis of the case revealed a complicated situation. The family history disclosed tuberculosis on both sides of the family. The general background was poor and unstable. The maternal relatives and the patient's immediate family were dependent upon public aid.

The home atmosphere was far from serene. The father was in poor health and took only a passive part in family life. The mother was erratic and inconsistent in her discipline and showed definite favoritism toward the boy's younger sister and an antagonistic attitude toward the boy. The home was shared by an aunt and an uncle, the latter adding to the difficulties by calling the boy a "sissy" and constantly teasing him in this way.

Further study of the case showed that the boy had been much attached to his grandmother, with whom he had spent much time. At the time of her death he had stayed with the family upstairs and had cried bitterly for her,

saying, "My grandma's gone." He was told by his mother that grandma had gone to New York. Two months later, however, he told his mother that his grandmother was dead, that she "went down a big hole." He continued to talk incessantly of his grandmother. Whenever he had a pencil he would write letters to her, often saying that he heard his "grandma calling him"; and when punished, he would say, "I'll go to grandma." He called for her in his sleep. His mother at times found him gazing at his grandmother's picture and holding imaginary conversations with her. When his mother interrupted him he would be very angry with her, saying he hated her, telling her to get out and stay out, and even trying to strike her.

The mother claimed that his attitude had changed completely since the grandmother's death. Whereas, formerly, she had had no fault to find with him, he now cried for the least little thing, had become bold, and was unkind and disagreeable to her.

From the account given by the mother one felt that the child presented certain symptoms quite malignant from a mental point of view and that he was in need of careful study and supervision.

The boy was normal physically but had many personality defects in his make-up. He was very jealous of his little sister and selfish with her, probably because his mother openly favored her. He held a bitter, antagonistic feeling toward his mother and said that he hated her. She interpreted everything he did as being "fresh and bold" and expressed herself as too disgusted with him ever to bother to praise him. His uncle's teasing made him feel inferior, and he resented being called "sissy." He preferred to play with dolls and games about the house, and it was not surprising to find that he had always been kept close to his family and was not allowed to play with other children. He was afraid of the dark and cried out in the night that pigeons were biting him. His mother admitted that she had at times frightened him in order to make him obey. He wet his clothes and had temper tantrums.

In the treatment of this case there were several factors to be dealt with. The most important was the mother, who had to be reeducated in her attitude toward the patient and in her methods of discipline. The father had to be made to realize his responsibilities and the child had to be educated to meet his problems in a more satisfactory manner.

The treatment consisted of frequent visits to the clinic and long talks with the doctor. The mother's attitude was changed: masturbation was stopped by means of diversion and the substitution of other interests; the child was desensitized to the dark through education and through his love of approbation; enuresis was stopped by the institution of routine measures; the boy was allowed to play outdoors with other children; and he was no longer teased or called "sissy." Within a few months the child made a perfectly satisfactory adjustment to his home and to his play activities. Subsequent investigation showed that he continued to make a very good adjustment to life.

Comment.—The foregoing case is not particularly different from other cases cited, except for the reaction of the patient to the death of his grandmother. With his playmates he met the situation in a fairly satisfactory way. He would talk about making trips with them to New York to see his grandmother, apparently refusing to think of her as being gone in the sense that she would never return, and undoubtedly lessening the sting by handling the situation as a child might be expected to do. With his mother he apparently faced the question openly and frankly, and his antagonism toward her indicates that he felt her to be responsible in some way for the grandmother's death. He stated that the grandmother was "in a hole in the ground." This was his conception of death, the child having none of the conceptions of the hereafter which those of his age usually entertain and which help them to face such sorrowful situations during their early years. When alone, however, he withdrew more completely from the realities surrounding the situation and carried on imaginary conversations. If these symptoms had been presented in a child 10 or 15 years older, they would have appeared to be rather definite psychotic symptoms, but in children it is extremely difficult to separate the products of daydreams and unfulfilled wishes from symptoms that have graver significance.

There is no cause for alarm if children have playmates of an imaginary character or if they hold conversations with their dolls or other toys. Not infrequently their own personalities split up tem-

porarily so that they are dealing apparently with two or three distinct individuals at the same time, asking and answering questions, praising one and punishing the other. It is these more imaginative children who make up the dreamers of later life, some of them achieving success because of these dreams, other falling by the wayside, unable to cope with their more materialistic brothers.

There is cause for concern only when these definite retreats are used by the child to meet some definite problem which has made unusual demands upon his powers of adjustment. Here it indicates, perhaps, a type of reaction which later in life may be developed and utilized to the disadvantage of himself and all others concerned.

Isolated fears are often found to be due to threats thoughtlessly made by parents or other people who are concerned with the problem of breaking some undesirable habit acquired by a child. This may be seen in the case of Gladys.

Gladys was 3 years and 1 month old when she was first brought to the clinic by her mother because of fears.

Birth was 3 weeks premature but normal. Her development was normal and her health history, except for pneumonia in infancy and several severe colds, was good. She was still wetting the bed at night and was receiving considerable attention during mealtime and bedtime. She slept well except after an attack of fear, during which she would stand up in bed and cry for her mother. She often had "muscular spasms," which came during the night, waking her out of her sleep. At such times she would scream violently, clutch at her mother convulsively, and become limp after a few minutes. The physician who examined her reported that these were not convulsions.

Being the only girl and considerably younger than her two brothers, Gladys was always the recipient of much attention from the family. She was, moreover, a much-wanted child, her parents having longed to have a girl for some time preceding her birth. An atmosphere was built up in which "everybody always shushed for Gladys." She became self-confident, happy, friendly, and affectionate, with no fear of people.

Her chief fear seemed to be of the wind. As a small child she had been in the habit of getting up in bed during the night and her mother had tried to stop this by threatening that the wind would blow over her and she would get sick if she did not stay under the covers. She began to think of the wind as a terrifying monster leaning over her, and she would become especially frightened when she heard the autumn wind blowing through the trees. Thunderstorms were terrifying to her. She was very much afraid of the vacuum cleaner and always stayed on a chair when her mother used it.

During one of her "muscular spasms" the patient began looking around in her bedroom as if fearing some horrible specter. She gave her parents the impression that her acute fear was due to the imagined approach of some dreadful monster whom she referred to as "pain."

This child had at one time had the habit of pulling her hair out and chewing it to such an extent that she actually had bald spots on her head. To break her of this habit, a friend of her mother told her that "some awful thing" would come and grab her hand away from her head. Although at that time she stopped pulling her hair, she began to have a continuous fear of this monster.

Another group of cases in which fear plays a very important part during the early part of the individual's life and is often carried into late adolescence and sometimes never completely eradicated, includes those cases in which some form of sex activity has played a part. Frequently sex problems are created in this way by the parents. One little girl who was battling the problem of masturbation happened to live near one of the State hospitals for the insane, and it was firmly impressed upon her that if she continued the habit she would eventually end there. She was taken around the institution

in order that the threat might be more firmly imprinted upon her mind. The child was told that everybody would soon know what she was doing—that they could tell by her expression and by the way she acted. Other children are threatened with operations under the same conditions. It is not unusual to find parents mutilating the fingers of young children, either by burning them or by pricking them, because of this habit.

It is hardly necessary to say how acutely sensitized the young, immature mind becomes to the habit of sex when such drastic measures are taken by interested but injudicious parents. Many of the inadequacies of adult personalities undoubtedly had their origin in feelings of inferiority that were stimulated during childhood. Apparently everything is done to make these children feel that they are different, and it is not surprising that they become shy, timid, and self-centered. Finding themselves in association with others who are quite intolerable to them, they seek solitude and build up in fantasy a dream world in which they can reside unmolested.

The situation of the child who flees from reality and finds consolation for his feelings of inferiority in a world of fantasy is well illustrated by the following case:

Harry had not quite reached 10 years of age when he was first seen at the clinic. He was described by his grandmother as being a lonesome, friendless child. She stated that her earliest recollection of the boy was that of hearing him tell her about an imaginary "friend boy" and that up to the time of his coming to the clinic his chief companions were various insects and imaginary children. He did not get on well with other children in school and was regarded as queer. He was very fond of old people and very sympathetic with them, being "very much upset," for example, over seeing an old lady crying in church. He was very responsive to music, singing church litanies to himself and improvising songs about fairies.

In spite of the fact that this lad had a good intellectual equipment, with an intelligence quotient of 121, his adjustment to school had been rather poor.

The boy was very restless during his sleep, talking as if he were fighting with someone, shouting, and tossing about, and occasionally laughing. His general health was good. He lived with his paternal grandparents, who had adopted him and his sister at the time of the death of their parents. The home, although small (a three-room apartment) was comfortable but obviously lacking in space for play. The problem presented was mainly one of withdrawal, daydreaming, and running away from life as it actually exists. The boy had an unusually acute imagination, was very keen in his observations, and could occupy himself with his fantasies for hours at a time. He would carry on imaginary conversations with a grasshopper, philosophize over the different cloud formations and what they might mean, and discuss with himself the observations that he had made upon the different kinds of trees and other living things. He appeared to be on intimate terms with fairies and he symbolized them by taking a couple of match sticks wrapped in silver paper and describing them as the fairy king and queen to whom he would sing. According to his grandmother these imaginary figures became so real to him that he would leave them with great reluctance, saying he was afraid to go away lest they be unhappy. He also had imaginary children as playmates.

During his psychological examination at the clinic he talked to himself a great deal, seemed to be thinking aloud, often about things that were irrelevant to the examination. His manner to the examiner was, however, responsive and friendly.

After helping his grandparents to build up a more objective sort of existence for this child by getting him promoted to the fourth grade where he belonged and by helping him make contacts with children in a "play group" who were more congenial than those of his immediate neighborhood, the clinic was able to close the case at the end of 11 months with the report that the child was making a satisfactory adjustment.

PROBLEMS ASSOCIATED WITH THE DEVELOPMENT OF THE CHILD'S SEX LIFE

Parents who at some time have received help from the clinic in the handling of a specific problem often come to regard the clinic as an educational center to which they may turn for advice and suggestions on various subjects connected with child training. They may wish guidance in choosing toys and play equipment or suggestions for children's books, or advice regarding a child's speech development, or help in considering a summer camp. No less frequently, however, they want help in handling some aspect of their child's sex education.

The question how reproduction occurs is one that every child with average curiosity will ask sooner or later unless some experience has made him unduly self-conscious and prematurely reticent. By the time a child is four, he has probably asked about the origin of babies many times. The answer given by the parents depends largely on their own sex adjustment and their attitude toward the subject. The clinic can be of great help, however, in giving parents an opportunity to think out and talk over some of the concepts which they wish to give the child.

The whole task of sex education can be made easier for parents if they are encouraged to keep these two thoughts in mind: First, that they must be absolutely honest as far as they go at any one time so that they will not be obliged to retract some of their statements later; and second, that they are telling the child about the normal, natural process of reproduction and not about sexual intercourse. The young child has no curiosity about adult emotional relationships or the actual process of conception. He is, however, vitally concerned and intensely curious about his origin, and the facts are so simple and understandable if presented frankly and unemotionally that the child can be completely satisfied. If parents will answer the question of the preschool child about reproduction without making him feel that he has introduced an unclean subject which only naughty children speak of, something will have been accomplished. It is a real achievement if the parent can make the child feel that he has brought up one of the most interesting topics in the world and if he can show the child, so far as his age and intelligence will permit, why it is interesting.

The knowledge of reproduction is in itself not so important as the attitude and emotional response which such an approach will foster in the child. In this connection the clinic can be of great help in giving parents an opportunity to rehearse—at least in their own minds—what their own attitude and emotional response will be. It is not enough for the clinic workers to tell a timid and inhibited parent that he must state the facts truthfully, for in that case the clinic worker is actually being as evasive as many parents. The

workers should be as frank as they advise parents to be. For many parents the experience of hearing another person speak of the sex organs by name, simply and correctly, is of the greatest benefit in helping them to overcome self-consciousness in approaching the subject.

Clinic groups that find it impossible or impractical to give this type of help to individual parents may accomplish similar results by arranging to have part of a parents' conference or one of a series of lectures for parents devoted to this subject. The clinic may provide the speaker or leader from its own staff, or may sponsor presentation by an outside person.

Reproduction is a topic to be neither featured nor ignored. Not all problems will be eliminated even when reproduction and sex are wisely presented to children, but the problems will be easier to manage, and parents will be in a far better position to help if they have been accepted by the child as guides and counselors. It is fortunate, indeed, that some of the taboos regarding sex are being lifted and that older children are no longer entirely dependent upon the parent and the home for honest information regarding these vital matters. The preschool child, however, must still depend on parents and parents must therefore assume the responsibility of seeing that the child embarks upon life with a wholesome outlook and an intelligent understanding of the process of reproduction.

In addition to helping parents in the matter of sex education, the clinic offers help in handling the various habits and attitudes arising in connection with the child's sex development. Common among these is the habit of masturbation.

Mothers of problem children frequently say that the habit of masturbation began at such an early date in the life of the child that it is impossible to tell when it did start. One child said that he had "handled himself" ever since birth. Such statements bear witness to the fact that the child may become aware at an early age that he can arouse pleasurable sensations by manipulating the genitals and other erogenous zones. This awareness is usually brought about by some external stimulation such as may be caused when the child is given a bath, when uncleanness gives rise to various irritations, when the child makes a rather minute investigation of his own body, and all too frequently when older children become curious about sex and make investigation of smaller children. In certain cases sexual precocity has been deliberately stimulated by irresponsible nursemaids.

It is not desired to convey the impression that masturbation begins so early in the great majority of children. When it does begin in these immature years it invariably lasts a short time. It may recur between the ages of 10 and 14. In fact it is so common during this period that a transitory period of masturbation about the age of puberty is generally considered quite normal.

The masturbatory act is usually carried on by irritating the external genitals with the hand, but children occasionally use sticks, pencils, and other small objects for this purpose. The act is often complicated by other manipulations which apparently add to the pleasure. Thumb sucking, rectal irritation, and rubbing the navel

are most common, and any one of these acts may be performed alone to the satisfaction of the child.

Visits to the toilet are frequently events of great interest to children, and it is not unusual to find that masturbation occurs only at these times. Not only their own visits to the toilet but those of the adult members of the household are of interest. One little girl was brought to the clinic on account of her interest in seeing people nude. She was accustomed to secrete herself behind the bed or in the closet or to peep through the keyhole and put many other ingenious schemes into operation to see any of the adult members of the family nude.

Other children are unduly sensitive about being in the presence of any member of the family while disrobing, and at a very early age they are what we commonly term "prudish" regarding the problem of sex.

Most of these youngsters, from a therapeutic point of view, fall into two groups: (1) Those who cling very tenaciously to these pleasures and in fact to all the pleasures of their lives, and (2) those who give them up with little reluctance. Members of the latter group need little or nothing more than to have their energizing forces sublimated along some more desirable path, and stress should be laid on the development of some new interest rather than on the undesirable habit. The treatment must be outlined to cover not a few days or a week but a period of several weeks. The parents' fears and anxieties over the outcome of the habit must be allayed so that they can carry out the treatment without undue emotion. All that is usually required in such cases is to attract the child's attention with a picture or a game when he is in the act of performing the undesirable habit. Other methods that require ingenuity may be used, such as directing the child's attention to some situation, even though it is only of passing interest, if it is sufficiently unique to hold his attention for the moment. The habit, of itself, gradually subsides. This habit in young children is not so serious as in older children with whom masturbation occurs only in seclusion, for in the early years the asocial quality of the act is not yet appreciated. Parents may be assured that no undue anxiety regarding these cases is justified if the child is directed with intelligence.

The cases that present the most difficult problem for treatment are those of children who turn to masturbation only when they are in unhappy or despondent moods. They find in this habit a source of comfort, and a comfort which is always at hand. As they grow older they may continue to indulge in the habit much as children turn to thumb sucking, especially as a means of inducing sleep. They may not experience any particular sex urge at the time, but they are bothered by a general, indescribable feeling of unrest, both physical and mental, which they find can be subdued if a sufficiently strong sex feeling can be stimulated.

The most practical method of treatment is as follows:

(1) Careful physical examination to determine whether there are any definite sources of irritation.

(2) Absolute cleanliness.

(3) Knowledge of those with whom the child is making intimate contacts.

(4) Knowing the child well enough to be able to understand his moods fairly well and appreciating the fact that masturbation is frequently sought as a retreat from unhappiness.

(5) Allaying the fears and anxieties of the parents and helping them to realize that dangers to the physical and mental well-being of the child are more apt to come from injudicious treatment than from the habit itself.

In any attempt to dispense with an undesirable habit something must be substituted for what is being taken away. Not only must approval replace disapproval, pleasure replace pain, and reward replace punishment, but some very definite and tangible method of sublimating energy must be presented to the child and presented in such a way that it can be utilized.

Considerable experience has shown that mechanical appliances which are used for restraining children are of little value unless the child is at an age when he can fully appreciate why the restraint is being used and can develop a state of mind in which he is quite willing to cooperate instead of resenting the treatment. If restraint is used forcibly the situation resolves itself into an open battle between the child and the parents in which both are doomed to lose; for invariably the child clings to the undesirable habit in spite of these drastic measures.

The following case is presented in considerable detail because it brings out several important points regarding the early development of sex interest in children and because it is further complicated by convulsions of an epileptoid character, which was the symptom that brought the patient under observation.

Frances, a 9-year-old girl, was brought to the clinic by a social worker for two definite reasons: (1) Because of convulsions which resembled epilepsy and (2) because of her precocious sex interest and sex delinquencies, which had begun when she was between 5 and 6 years of age. The episode that brought the child to the attention of the referring agency was that the child's teacher found an obscene picture in her possession.

Physical findings were negative, except for a positive tuberculin test and the "spells" which resembled petit-mal attacks. The gynecological examination that was made on account of the social history indicated a certain amount of irritation of the genital organs. The child was well developed and well nourished.

The child's intelligence quotient was found to be 111. Mental findings graded the child 1 year above her chronological age, which gave her an intelligence quotient of 111 on the Stanford scale. All the tests given were responded to at about the same level except that for rote memory, which was particularly good, and that for practical judgment, which was below her mental age. She was much interested and entered eagerly into the spirit of the tests. She was in the third grade at school and was capable of doing work above the average. The teacher considered the child very bright but stated that at times she appeared extremely absent-minded.

The parents reported that the child had "immoral habits," that she never sought girl friends but was always in the company of boys, and that she had immoral relations with them.

No information was obtained regarding the grandparents of the patient, but her father appeared to be a fine, self-respecting man, who was making every effort to do all he could for the welfare of his family. The child's mother had died 4 years previous to the time of the clinic visit. She had been epileptic and hypersexual to a marked degree. She died at a psychopathic hospital in a toxic psychosis. The child's father had married a second time and the step-

mother seemed to be kindly and affectionate toward the child and interested in her welfare. In matters of discipline concerning the younger children, she received but little support and encouragement from the three older married sisters in the family.

The child had been living at home with her father, stepmother, and brother John, aged 13. The latter was said to be a quiet boy but it was learned that he indulged in petty stealing and had been arrested twice. There were three older married sisters who continually interested themselves in the father's household, much against the wishes of their stepmother and probably to the disadvantage of the home. The father stated that none of his children seemed normal. He had always had difficulty in bringing them up. They were delinquent, misbehaved, and had bad reputations. On the whole there seemed to be nothing obvious in the immediate household to account for the delinquent tendencies of the children.

For the last 3 years Frances had interested herself in boys, although according to her own story she did not exclude girls as companions in her erotic indulgences. From the history it appeared that the patient had been more of an influence on the environment than the environment had been upon her. The father stated that since the child was 3 years of age she had shown an abnormal interest in sexual things and had been quite aware of her own sex feelings and how to stimulate them. When returning from the moving pictures she appeared to remember nothing but the sensual aspect of the picture. On several occasions the patient had been found in the cellar of an unoccupied house, with three or four boys of her own age. She told her father what had happened and showed no sense of shame in speaking of the active part she played in these episodes.

In the doctor's office she answered all questions frankly and showed herself an extremely precocious individual with an intimate knowledge of sex affairs which could have had its basis only in personal experience. She made no effort to minimize her part in these events and voluntarily expressed a desire to overcome these hypersexual tendencies. She discussed the entire situation without embarrassment, went into the minutest details, and discussed her innermost thoughts and dreams in an interesting and enlightening way. She appreciated the effort that she must make in order to overcome the cravings and desires responsible for her past difficulties. She was also anxious to develop other interests to substitute for her erotic daydreams. At no time did she blame others for her trouble, and she stated that she was extremely anxious to overcome her undesirable habits in order to make it easier for her stepmother, to whom she was apparently very much attached.

This case presented two definite problems for solution: (1) The convulsive tendency and (2) the precocious sex interest and sex delinquencies. Physical findings in the case were essentially negative. Mental findings indicated that the child had more than ordinary intelligence. Her teacher considered her bright. The delinquent behavior might have been considered accidental in origin and as being continued because of hypersexual cravings. Home conditions were not ideal, yet they were not sufficiently difficult to account entirely for the strain of delinquency found in this family. Associations were neither better nor worse than those found in many districts. Nothing in the mental make-up of the child or in the environmental conditions stood out distinctly as the exciting factor of her difficulties.

The effect of such a series of experiences upon the development of character and personality in the child is open to conjecture. The reason for the particular experiences at such an immature age in this individual case may well be considered as environmental or accidental. The effect of such an experience depends upon circumstances and conditions that are beyond the control of the child, and the solution is quite as dependent upon accident as was the origin of the primary experience.

The fact that this child was of rather high-grade mental equipment and somewhat precocious in her interests other than her sex interests was indeed fortunate, for the experience could be very well assimilated and digested by the child, minimized by the parents, and perhaps turned to some good purpose. On the other hand, the habit might be repressed so completely as to lose its own identity entirely, only to appear in some quite pathological condition or some definite asocial act—as apparently occurred with this patient in her hysterical episodes. Again, the experience might be rather imperfectly repressed; and continually and persistently forcing its way into consciousness, might produce

disintegration of the personality such as is manifested in many of the psychoneuroses of the neurasthenic and anxiety types.

From a physiological point of view it is not difficult to conceive of such early sex experiences as sensitizing the individual to subsequent emotional experiences of a sexual nature and producing a hypersexual individual whose sexual outlet may be prostitution, homosexuality, or other perversions. Notwithstanding the fact that this tremendous physiological sexual drive may exist, it is not unlikely that such an experience would produce a psychological repugnance to sex, the two forces combating each other and resulting in conflicts that torment and incapacitate.

While the child is passing through these experiences she needs all the help and understanding that she can get from those having the case in charge. To wait 20 years and then begin philosophizing about the effect of such early sexual experience and its relation to the nervous breakdown of an adult is perhaps easier than to get a clear, concise picture of just what is taking place when the child is passing through the experiences. But there is no comparison in real value between gaining information while the forces are operating and guessing later what actually happened, how the mental mechanism worked, and what effects the experience had on the development of the individual.

PERSONALITY CHANGES FOLLOWING ILLNESS AND INJURY

Parents are frequently inclined to blame an illness, an operation, or an accident for some change in the behavior of the child, when a careful examination and thorough investigation of all the facts surrounding the problem would indicate that the illness or accident has been to blame only in so altering the relationship of the child to his environment as to allow these personality problems to develop.

It is only natural that parents are deeply concerned when a child is ill, especially if the condition is at all serious. Their anxiety over the welfare of the child is often out of all proportion to what the situation really warrants. Whether the child has been cared for at home or in a hospital, the period of illness and convalescence is one during which the entire household revolves around the child. The other children are instructed to give in at all times to the ailing member. His every want is anticipated, and his demands, however numerous and varied, are satisfied at the earliest possible moment. He is in a position to commandeer everything in his environment and, needless to say, it is not an unattractive situation in which he finds himself.

For the first time, so far as he can remember, he is the center of attraction and attention. He never before appreciated just how important he really was. Before this illness he had had to give and take with the rest of the family. He had his responsibilities and he was expected to "carry on" like the other children in the family. He took his shares of punishment and accepted it, but now everything has changed to his advantage. It is therefore not surprising that the child who finds himself in this situation should get an exaggerated idea of his own importance and that after he has enjoyed these indulgences on the part of the oversolicitous parents he should cling rather tenaciously to his new position, being reluctant to give up the symptoms which created it.

A typical example is that of James, whose mother said, "James is very restless, cries easily, twitches his arms and body muscles, is very irritable, flies into tempers, and cannot sleep nights." This change appeared after his return from a hospital where he had been treated following an accident. He became very surly, always looked ugly, seldom smiled, and appeared unhappy and discontented. He had become so different since the accident that the boys started to call him "Empty-head." The problem confronting the mother was whether she should follow the advice of her lawyer and sue for damages. Fortunately, however, her primary interest was in the recovery of the lad. Inquiry revealed that since the accident the routine of the household had revolved around the patient. Every whim was gratified regarding his food; other children were notified that they must accede to his every wish; all the toys were his to accept or to reject; and the lad found himself in the limelight.

After a careful physical and neurological examination had been made, it was planned to change the regime of the household. The mother was to revert to the old plan of making the child give and take and battle for what he could get with the rest of the children. In just 1 month his mother reported that he was

happy and contented and played with the other boys, had lost his surliness, was getting along well in school, and showed no evidence of the personality change which was so apparent when he first came under observation.

Many of these problems might have been avoided had the parents appreciated just what all this attention might mean to the child. The most important part of most illnesses is the convalescing period. At this time the parents must use the best judgment to avoid not only prolonging the illness but creating attitudes on the part of the child toward the illness which cause trouble later. Quarrelsomeness, jealousy, selfishness, disobedience, sullenness, tempers, and many other undesirable personality traits may have their origin during the convalescent period.

Although many of these personality changes have a definite psychological basis, it has been recognized within the last 10 years that many cases of marked personality change are the result of encephalitis. These changes may manifest themselves in a deep apathy or a marked hyperactivity characterized by irritability, destructiveness, and not infrequently by violent temper. Occasionally delusions and hallucinatory experiences are also associated with them. Such changes are usually preceded by a fairly typical history of encephalitis, which should ordinarily not be confused with other diseases. There are, however, a number of cases in which the attack was so mild that the diagnosis of encephalitis was not made but which were nevertheless followed by marked change in personality.

This point should be kept in mind in making a diagnosis and planning treatment. Obviously the ordinary clinic measures carried out on a psychological level or any reconstruction of the environment do not materially alter the conduct of these children. The treatment to a very large extent is one of reeducation under adequate supervision.

Another situation that may arise with reference to personality changes and their relation to accidents is brought about when parents take the opportunity of blaming illness and accidents for undesirable behavior. Thus, the mother of an 8-year-old child gave a history of the child's lying, stealing, being cruel, and other asocial conduct as beginning after a coasting accident which took place about a year before the time of her coming to the clinic. A subsequent social investigation revealed, however, that this child had been a serious problem at home, at school, and on the street for several years; that he was well known to the police and the truant officers; and that although the accident itself and the attention which the child received may have exaggerated the situation, it could in no way be regarded as the cause.

Undoubtedly certain peculiar personality traits are developed by children who suffer from such chronic diseases as diabetes and cardiac conditions which have limited their activities and prevented them from participating in a normal way with children of their own age and by children who have been the victims of illnesses like infantile paralysis which leave physical handicaps. Usually, however, those children who are handicapped by infantile paralysis in early life are remarkably free from personality changes. This may be due to the fact that the limitations imposed by the illness are present at such an early age that the child learns to live with the difficulty from the very beginning. Furthermore, the handicap is

of such a nature that his contemporaries make certain allowances for it. The cardiac and diabetic children, however, have no such obvious defect. Children with heart conditions become overwhelmed by their inability to compete with other children after they have recovered from the disability and so may develop a feeling of inferiority. But the diabetic child is more likely to become critical, irritable, resentful, and defiant unless wisely managed from the beginning of his illness. These personality traits are not characteristic of the respective illnesses, but they are observed with sufficient frequency to be worthy of comment.

It should always be remembered that every family has its own history and its own associations which color its attitude in a new situation. Prolonged and exaggerated solicitude over a child who is ill with measles may seem quite out of proportion to the cause until one learns that an older child lost his hearing following an attack of measles. It is important to get a complete history in order to interpret these situations correctly and arrive at a practical therapeutic approach.

The following case, discussed in some detail, is of interest in this connection.

Randolph was referred to the clinic at the age of 3 years because of a personality change first noticed on his return from the hospital, where he had been confined with diphtheria. He was quarrelsome and had frequent temper tantrums, during which he threw himself on the floor and kicked and screamed for long periods. At night he refused to go to bed unless accompanied by his mother, and occasionally he had night terrors. In addition, he was capricious about food and had developed the habit of soiling himself daily.

This boy's birth and early development were uneventful except for a mild attack of scurvy when he was a year old, and the attack of diphtheria already mentioned.

The father had suffered a nervous break-down a year before. Although he was occasionally irritable he was, on the whole, a generous and considerate father and an excellent provider. The mother was well meaning, but highly neurotic and unstable and she had many superstitious interpretations of the simplest incidents. An older boy had died of diphtheria and she had not fully recovered from her sorrow, a fact which had considerable bearing on her present condition. Besides a younger brother there was in the household the maternal grandmother, who interfered greatly with the discipline. According to the mother the grandmother "would turn the house upside down to please the children, as she hated to hear them cry."

Prior to the boy's illness his mother had noticed nothing peculiar in his behavior, but following his return she had observed a decided change. He was sullen, irritable, seclusive, and unreasonable. He expected more than his share of attention and went into a tantrum when it was not forthcoming. He went to the window every night before retiring and, looking upward, bade good night to God and his older brother—a practice which his mother considered uncanny and unexplainable. He had not been permitted to play with the other children in the neighborhood because of his peculiarities and because none of them were his age. The mother complained that it was impossible to have the child remain in the bedroom alone before going to sleep—he begged her to remain with him to make sure there were no wolves outside the door. He entertained this constant fear of having wolves enter the room.

On his first visit to the clinic the boy refused to leave his mother or to permit her to enter the examining room without him. When she left he flung himself upon the floor and remained there in a rigid state until her return. She then picked him up and allowed him to bury his head in her bosom, simulating a nursing child. He later began to pout and talk in a babylike fashion but refused to converse with the examiner.

The intellectual equipment of this boy was about average. He had an intelligence quotient of 98.

This is a case which superficially would impress one as having all the essentials of an early mental aberration, were one to base one's conclusions entirely on the mother's interpretations and findings without further analysis of the situation. Indications which the mother accepted as being highly ominous were really nothing more than would be expected in a child of this particular make-up living in such an environment and influenced moreover by a factor which will be mentioned shortly.

The mother, grief-stricken over the death of her older son (who had died while the patient was convalescing), attempted to compensate for her loss by indulging the patient to an unlimited degree. Everything began to center around him. He was the one attraction in the house and all the members of the household exhibited their joy at his recovery. The child saw himself in this prominent and not unpleasant position and it was not long before he took full advantage of it by making numerous demands which the family readily granted.

At one time the family had employed a maid who had nightly threatened the child with a wolf story before he went to bed. She used this story in an attempt to hurry him to bed and always warned him to remain in the room lest he be captured by the wolf. This bit of information revealed the origin of his fear of wolves.

Later it had been the grandmother's privilege to prepare the patient for bed. She would undress him, hear his prayers, and, before putting him to bed, take him to the window and have him bid good night to his deceased brother, who, she explained, was watching over him with God. When the development of this particular practice was explained to the mother she no longer looked upon it as being a mysterious procedure but realized that it was simply what his grandmother had taught him.

Much of the success of the treatment in this case rested on the mother's acceptance of modern methods of dealing with the child's problem and the destruction of many of the superstitions which had previously handicapped her. After a short psychotherapeutic talk she was found to be most cooperative and willing to carry out the treatment in detail.

A chart was given to the mother to help her solve the feeding problem, and measures were taken to desensitize the child to fear of wolves. He no longer was to assume the role of invalid but was to take his place in the household on an equal footing with his younger brother.

The child made three visits to the clinic. On his last visit his mother reported that he went to bed unaccompanied, that he no longer talked about wolves, and that he had earned his complete quota of stars on the chart. His marked aversion for milk had been overcome and he drank it unprotestingly with every meal. The family was leaving for a summer resort where it was hoped he would be given a wider opportunity for contacts with children of his own age.

CONVULSIONS, TICS, MANNERISMS

When one considers that more than half of all individuals suffering from chronic convulsive disorders in adult life, the so-called epileptics, had their first convulsion prior to the fourth year of life, the importance of convulsions in children becomes apparent. This does not mean that the isolated convulsion which sometimes ushers in an acute infectious disease in children need be taken too seriously or cause parents undue anxiety. Any child, however, who has a series of convulsions or is prone to react to infections, falls, and emotional stresses and strains by having a convulsion is in need of the best medical attention.

A study was made of a group of children under 4 years of age who had been patients in hospitals and had suffered from convulsions associated with acute infections, spasmophilia, gastrointestinal upsets, rickets, and whooping cough. These cases were carefully followed up to discover their subsequent history. A surprisingly large number of these children eventually died of convulsions and many of those who were still living continued to have convulsions or were mentally deficient. The implication of this study is that convulsions in children should no longer be looked upon as a mere incident in their medical history nor as something that happens to every child, like an increase in temperature or a gastrointestinal upset. The convulsion itself must rather be considered as a certain criterion of the inherent instability of the nervous system. Some children are so inherently stable that the convulsions associated with actual irritation of the nervous system (such as is seen in encephalitis) may subside and leave no ill effects. This indicates that there is no well-defined limit to the amount of brain irritation that may occur without leaving ill effects. It appears that some nervous systems are capable of withstanding a rather severe disturbance such as would naturally be produced by an acute inflammatory condition of the brain. Others will succumb to a mild infection or a slight trauma, leaving behind an increased instability which responds more or less periodically to the minor vicissitudes of life and manifests itself in convulsions.

From the standpoint of preventive medicine it does not matter whether these early convulsions are of psychogenic or of biochemical origin. There seems to be little doubt in the minds of those most interested in the subject of epilepsy that each convulsion paves the way for the succeeding one, and that the path becomes deeper and the line of demarcation sharper and more easily traversed by the excess of liberated nervous energy. For this reason it is tremendously important for the future welfare of the child that a careful investigation be made, by both clinical examination and laboratory tests, to determine the exciting factor in the production of these infantile convulsions.

It is important for the pediatrician and the psychiatrist to work hand in hand. The former usually sees the child over a short period of time, but it is an extremely important time when the undesirable forces, whether they are psychogenic or chemical, are operating. The

latter, on the other hand, sees the child over a longer period of time, but invariably at a period somewhat removed from that in which the exciting factors actually operate. Until a better working knowledge is obtained of the baffling phenomenon called epilepsy, it is especially important for the psychiatrist and the pediatrician to cooperate and to have a clear knowledge of each other's technique. In almost every case of a convulsive disorder it is necessary to look for both a predisposing and an exciting factor.

There is no group of cases today more worthy of the attention of those best qualified in the practice of medicine than those of early infantile convulsions. It has been said that "the child, for the first 5 years of life, is an organism so tender, so easily broken, so easily damaged, that it needs all the care that first-class intelligence can give it."

Susan, a poorly nourished and underdeveloped girl, 6 years of age, was brought to the clinic by her mother for a series of problems of which fainting spells were the most important.

There was no history of epilepsy or mental or nervous diseases in the family. The child's birth and early development had been normal; she had had the ordinary diseases of childhood. There was no history of convulsions, but the mother stated that the child, since she was 8 months of age, had had spells during which she had momentarily lost consciousness. These fainting spells, so called by the mother, usually took place when the child found herself in any difficult situation. When threatened with punishment she would fall to the floor in an apparent faint. She would hold her breath and get blue in the face. The mother would then pick her up, fondle her and put her on the bed, and the episode would be over. At other times these "fainting spells" would follow one of her temper tantrums. She would lie on the floor, kick, and yell, holding her breath for varying periods and apparently losing consciousness. She might, however, have one of the temper tantrums without the fainting spell.

The mother stated that the child was very affectionate but domineering. She always wanted "to be the boss," whether at home or at play, and usually got her own way. She was extremely stubborn and when refused she responded in the manner already described. She was said to be friendly and generous. She was jealous to the extent that she demanded at least as much attention as was given to the other children in the family. The mother repeatedly stated, "The child must have her own way. The only way to manage her is to give in to her."

Comment.—The foregoing history, in association with the negative physical examination, stamped these "fainting spells" as belonging to a psychogenic group of reactions. It seemed quite obvious that the child was utilizing this method to gain her own way. It is always difficult in a case of this kind to divorce the physiological aspects from the purely psychological. For example, the effect on the oxygenation of the blood of holding the breath might in itself produce unconsciousness. This case was stamped as being psychogenic by the fact that the treatment, which dealt entirely with teaching the mother how to deal with the child during one of these "fainting spells" or temper tantrums, completely relieved the symptoms. At the time of the last visit the child had not had a spell for over 2 years, although she occasionally met an unpleasant situation with the cruder method of tantrums.

The case of Theodore may also be mentioned. The child, aged 2 years and 5 months, was brought to the clinic on account of severe temper tantrums, which only recently had terminated in convulsions. When one considered the complete disintegration of the mental life of this patient as indicated by violent temper, insomnia associated with night terrors, enuresis, pugnacity, extreme jealousy, selfishness, destructiveness, and masturbation, it was not very difficult to explain the convulsions as one of the numerous manifestations of an inherently unstable nervous system. This manifestation at times might follow the sexual excitement of masturbation or the extreme emotion attached to a temper tantrum, and at other times it might be the manifestation of more definitely physiological causes,

such as would be associated with excessive fatigue, lack of sleep, or marked indiscretions in diet. The treatment had to be directed not toward the convulsions but rather toward rehabilitating the individual as a whole.

Billy, aged 4 years, was brought to the clinic because he was extremely stubborn and difficult to manage and was seemingly quite insensitive to the praise or blame of those in his environment.

In this case the first convulsion occurred at the age of 13 months and was associated with an acute infection of the influenza type. Since that time the child had had nine convulsions, occurring at intervals approximately 6 months apart. These convulsions had invariably been associated with some acute illness. One spell was associated with an acute febrile condition which lasted several days. One occurred after circumcision. Several others were in association with definite gastrointestinal upsets at the hospital. The convulsions in this case never occurred with any emotional experience, but always at such times and under such conditions that it was difficult to determine the exciting cause.

Another important factor in this case was the fact that the child was retarded mentally. When the convulsions begin at such an early age mental retardation is common. Mental deficiency of this type should not be looked upon as congenital or due to defective germ plasm. It must be assumed that the child whose nervous system is so unstable that he reacts to an acute infection with a convulsion is somewhat handicapped from the start, but that does not by any means indicate that he would have been mentally deficient if he had not had the convulsions. Many of the physical abnormalities seen in children, such as monoplegias and hemiplegias, are not congenital but appear during the first 2 years of life, following convulsion. This is a practical as well as an interesting point to be kept in mind when considering the general subject of heredity.

The treatment in such a case, so far as the convulsions are concerned, is obviously not one of psychotherapy. A special regime should be instituted in which the amount of physical and mental stress should be definitely limited. Diet is of paramount importance and one should avoid all the more indigestible articles of food and the methods of preparing food which render it less digestible. Tea, coffee, and other stimulating as well as irritating articles of diet should be eliminated. Constipation is invariably found in these cases and should be guarded against. It is best combated by a carefully selected diet, which should include much fruit, green vegetables, and bread made of whole wheat. After such a case has been carefully studied to eliminate every possible physical cause, and the proper regime has been instituted, it may also be necessary to use some drug. The treatment of such cases should always be directed by a physician.

There are many and varied physical manifestations indicating disturbance of the nervous system in children, and from the beginning all such symptoms should be considered as having a physical basis and should be referred to a physician. Chorea is one of the most common examples of what an infection may do to the nervous system, especially in a child who is inherently unstable. Chorea is usually associated with rheumatism, and the symptoms are undoubtedly due to a mild form of meningitis. Motor unrest and mental irritability invariably precede the characteristic, involuntary movements which involve the arms, legs, and frequently facial muscles. These movements may become very violent at times and the child will throw himself about in a manner that may do him bodily harm. Although it is now generally recognized that chorea is due to an infection, fatigue and excitement markedly exaggerate the symptoms.

Habit spasms sometimes present a picture that is closely allied to chorea, but the muscular involvement is less extensive, usually affecting only one group of muscles of either the upper or the lower extremity.

The spasm may take the form of blinking the eyes, wrinkling the forehead, and making a pulling movement of the facial muscles, especially the nose, which result in peculiar grimaces. Spasms of spitting, coughing, and peculiar types of breathing are also observed frequently. When these involuntary movements have been present over a period of months or years, they frequently resist treatment and an absolute cure is not always possible. This accounts for the fact that many adults are still afflicted with habit spasms that were acquired during early life. There is undoubtedly a predisposition on the part of some children which permits the ordinary stresses and strains of everyday life to throw the coordinating mechanisms of the brain out of adjustment. The first evidence of this instability may be precipitated by fright, grief, intense anger, or physical fatigue. These habit spasms are not infrequently seen in children when there is a history of prolonged mental exertion, as for example, the child who is subjected to a school program plus outside activities such as music and dancing lessons that make up an intellectual and physical load beyond his ability to carry. These symptoms are but the first evidence that the child is working too hard.

One must keep in mind, however, that in dealing with these problems it is not the symptoms but the child who needs treatment, and every effort should be made to determine the emotional stresses to which he is being subjected. Such an investigation leads in various directions. The discipline in the home may be too rigid; an ambitious parent may be pushing the child too hard; the child may be suffering from extreme anxiety in his personal relationships with his teacher or over failure in his work. Often teasing and bullying by his contemporaries supply the answer to the problem. Besides these more obvious situations, fears and anxieties of which the child is not aware may be operating below the level of consciousness. The symptoms are of such a nature that parents are sometimes worried and irritated and are prone to put considerable pressure on the child to make a greater effort to overcome what they consider an unattractive habit. They do not realize that the more conscious the child becomes of his difficulty the more likely it is to be exaggerated, so that nagging, scolding, and punishment are not only useless but harmful. Under a physician's direction the child should be removed from the irritations of his environment. He should have complete rest, and general routine measures for building up physical health, such as proper food, sleep, and elimination should be put in force. After the acute symptoms have subsided, it may be necessary to make important changes in the child's daily routine.

The early manifestations of these involuntary muscle spasms are often detected in a clinic when the child is brought in for some other reason. It is during the early and incipient stages of these emotional upsets that valuable preventive work can be done. These problems in themselves are not serious medical problems, but certain attitudes that develop around the problem have important implications. The child may become very self-centered, shy, and diffident, showing marked feelings of inferiority which lead him to refrain from entering into activities with other children and prevent him from developing a normal, healthy outlook upon life. Early recognition and treatment are therefore imperative.

THE CRIPPLED CHILD

The White House Conference on Child Health and Protection in 1930 called attention to the fact that "there are more than 10,000,000 children in the United States who are 'handicapped'—in the sense in which the term is here used—i. e., children who are blind and partially seeing, deaf and hard of hearing, crippled, who are mentally deficient or disordered, who are suffering from tuberculosis, cardiac or parasitic diseases."⁶ This is a very conservative statement, yet it indicates the magnitude of the problem and is a challenge to those responsible for rehabilitating, so far as possible, the physically and mentally handicapped child. The problem is further complicated when consideration is given to the interdependence of the physical, intellectual, and emotional aspects of life and the extent to which the individual's personality, his general outlook on life, and his capacity for happiness and efficiency may be materially and permanently affected by the wisdom with which handicaps are treated in early life.

The effect of physical disease, injuries, and accidents on the personality of the individual has already been discussed (pp. 82-85). The chronically ill and the permanently physically handicapped have some general problems that are not unlike those found in persons suffering from acute conditions, though it must always be taken into consideration that a particular handicap may exert a specific effect upon the personality make-up of a particular individual. The fact that one's mood or feeling of well-being is affected by the condition of the bodily organs—that is, the functioning of the liver, the gastrointestinal tract, the thyroid gland, and so forth—is so well understood that it needs no further discussion. It is not so commonly understood, however, that emotional responses toward life, such as worry, grief, or anger, affect the functioning of the bodily organs; that high blood pressure, indigestion, diarrhea, pains, or hyperacidity may be the result of a love affair, a disastrous speculation, or the loss of a job; and that cause and effect can be demonstrated, whether from the point of view that feeling tone is affected by physical ailments or vice versa. The whole problem may become very much involved, but for practical purposes it is important to keep in mind that the patient's mental attitude toward his illness or his physical handicap is of paramount importance—so important, in fact, that this attitude in itself may account for so-called personality changes and for much of the resulting incapacity.

During the last 2 decades the attitude toward the crippled child has gradually changed. Society, families, and individuals have been in the past rather prone to view these unfortunate individuals sympathetically yet pessimistically, accepting them as responsibilities for home and institutional care who were entitled to kindly consideration

⁶ White House Conference, 1930: Addresses and Abstracts of Committee Reports, p. 292. Century Co., New York, 1931.

and adequate custodial supervision when facilities were available. With the development of improved surgical techniques, deformities and resulting handicaps have been greatly reduced. This has meant that certain children who were suffering from a form of physical handicap previously considered permanent have had complete correction of that deformity. Other children whose deformities could not be corrected have had normal function restored through treatment so that the deformity is no longer a handicap. With better insight into the incapacitating aspects of the mental attitude toward the handicapped, efforts have been made to consider the individual as a whole and to find some life occupation in which his deformity would be minimized and his assets given the fullest opportunity for expression. This attitude on the part of society toward the crippled child has opened many new channels through which the handicapped individual has been able to find adequate outlets for his potential physical achievements and his emotional and intellectual satisfactions. Parents, having been awakened to this new social optimism in regard to the handicapped child, have felt less sensitive about these unfortunate members of the family and as a group are seeking all available assistance as soon as they recognize the problem. Under such conditions we have a right to anticipate earlier recognition of the child's needs, better medical care, help and guidance in the selection of a vocation, improved mental attitudes on the part of the handicapped child, and in general an increase in his happiness and efficiency.

The most important therapeutic contribution that can be given to the crippled child is the assurance that there is a place for him in life, that he has a contribution to make to justify his existence, and that effort on his part is worth while. Only in this way can the will to attain the maximum degree of independence be established within the child. When this is accomplished the handicapped individual no longer indulges in introspection and self-pity but turns his attention to the outside world, where he can now find guidance and direction in preparing himself for a life of usefulness. It must be kept in mind that the attitudes which the crippled child assumes toward his handicap will invariably be but a reflection of attitudes shown by those with whom he comes in contact during his early years. The parent who is constantly reminding the child that he cannot do this or that because of his limitations or the dangers involved will contribute little toward helping him build up the attitude of confidence which is essential if he is to utilize his assets to the fullest extent. On the other hand, if the child is reared in an environment where his physical limitations are relegated to the background, where he is being constantly presented with opportunities and tasks that are well within his ability, and where his attention is focused toward intellectual interests, he soon learns that there are many ways and many opportunities by which he may compensate for his particular handicap. Every handicapped child should be not only permitted but encouraged to do everything he can possibly do for himself, and the assistance that he receives should be limited only to those tasks which are definitely beyond his ability. Only in this way will he attain that sense of normality and independence which is essential

to his ultimate success. The child who has acquired a healthy attitude toward his handicap and a sense of independence will embark upon the task of fitting himself for life with confidence and courage.

The next important step perhaps is that of selecting a vocation. Here again guidance and training are important, and the problem of determining the work which is best suited to his particular abilities and in which his handicap will be least in evidence needs careful consideration. The wise counselor will realize that the work should be selected with the idea of giving the individual not only the opportunity of doing his particular task efficiently but also the maximum amount of emotional satisfaction.

Especially careful consideration should be given to the type of vocation selected for the handicapped child. One naturally selects a field of training that offers opportunity for subsequent employment. Insofar as it is humanly possible, this particular group of individuals must be safeguarded from failure. They are invariably sensitive and are inclined to compare themselves to their own disadvantage, with those unimpaired by handicaps; and they are prone to think in terms of what they might have achieved were it not for their handicap. It is, therefore, important that they attain success regardless of what the job may be. This is essential if confidence is to be acquired and if they are to become self-sustaining in the field of industry. It is obviously more difficult for the handicapped to throw aside training in one activity and start over in something new. No effort is too great nor time too precious to spend in helping the handicapped child to overcome those difficulties and surmount those obstacles which obstruct the path to a happy, useful, productive life. Every handicapped child must be considered as an individual needing special consideration. These children should not be looked upon as cases to be dealt with in any routine, mechanical way, as one might deal with a piece of defective machinery. They are human beings struggling to make a place for themselves in an environment in which they will meet keen competition, under conditions which, to say the least, call for all the help that science and human consideration have to offer.

One need not look far afield to find shining examples of the victory which modern surgery, wise counseling, and vocational guidance, associated with confidence and courage, have won for the handicapped child. Many of these individuals have reached peaks in their achievements, not in spite of their handicaps but because of them. Many of these young people have been stimulated to greater effort, have acquired a finer sense of values, have been aroused to loftier ambitions, and have been generally stimulated in the right direction by virtue of their handicap.

It is impossible to lay down specific rules and give definite information on how to direct the activities of any individual handicapped child. Keen appreciation of the desired objectives and of the fact that the case involves a human being and not just a deformity will do much to help the handicapped child develop to his highest degree of usefulness from a physical and an economic point of view. It will also create in him attitudes toward himself and the world that will give him assurance of his own worth, a feeling of independence, and a sense of security about life in general.

MENTAL DEFICIENCY

Although the problem of mental deficiency is not one of primary concern to the habit clinic, it is an important problem of childhood and one that is directly related to behavior problems. Imbeciles and idiots are obviously cases for institutional care, but high-grade defectives must often be cared for in the community. The social maladjustments of the latter group are due not to the mental defect as such but rather to the accompanying mental instability. Since the advent of so-called intelligence or psychometric tests, the large number of mental defectives in the population has become more apparent, and it is realized that but a limited number can possibly be cared for in institutions. As a group they are, moreover, neither bad nor vicious, and they may serve a very useful purpose in the industrial world.

Mental tests are of real value in determining within reasonable limits the intellectual load which any child is capable of carrying. The results of such tests should receive serious consideration, however, only when the tests have been both given and interpreted by one who is expertly trained.

In testing the preschool child there are several points to keep in mind:

(1) Considerable time is required to establish friendly relationships with the child.

(2) In addition to having the child in a cooperative state of mind, it is frequently essential to get the intelligent cooperation of the mother. The child who embarks upon a psychological examination after having just overheard his mother say, "He is stubborn and won't do a thing unless I am right with him," has been given every incentive to do nothing whether the mother is present or not.

(3) It is absolutely essential to have a clinical psychologist who has sufficient imagination and flexibility and has had sufficient experience to elicit the child's maximum efforts and to evaluate the results. He must keep in mind that these children have not had the standardized training of the school. Children of preschool age who come to the clinic are often shy and reticent, afraid of new surroundings, indifferent, or inattentive. They may come from homes where little training or stimulation has been offered them. There may be language difficulties. Giving mental tests by any rule of thumb is therefore even less practical with the preschool child than it is with older children. If they are so applied, a shy, diffident, unstable child of superior intelligence may appear backward or even defective.

(4) In spite of the advances that have been made in tests to measure the intelligence of preschool children, there are still relatively few that are standardized. Nonlanguage tests are practically essential, and in checking test results a certain amount of leeway must be given the examiner, thus allowing for the child's interests and

activities at home and for his fund of general information. If it appears worth while to make a psychological examination of a child, as full a sample as possible should be made of all his abilities and disabilities.

The advantages of these examinations may be summed up briefly as follows:

(1) Unfortunate and deficient home training is shown by these examinations at an age when those trends of mental development which are stunted can be stimulated. In many cases this implies the possibility of preventing special disabilities and intensifying special abilities. The child who shows underdevelopment in ideational or verbal fields can be given special story-telling advantages—can be read to more. The child with inferior manual ability can be given more and better opportunities for manual work.

(2) Children who have unusual precocity of a specialized type (for music, color, and so forth) or of a general sort may have this precocity appreciated and developed.

(3) Children examined before starting public-school work can be put into special classes to see how much of the retardation is real and how much apparent, thus avoiding the undesirable sequelae of early school failure, the clogging of normal primary grades, and the stunting of a precocious mentality.

(4) It is essential for successful therapy with neurotic children that their intelligence be known. Obviously the feeble-minded and the precocious cannot be given the same treatment.

A careful psychological examination should be considered an important and essential part of every attempt to understand a child and his particular problem. It is important to keep in mind that the clinic has not only an obligation to the defective child but also a responsibility to the family in which that child lives. It is invariably necessary to point out to parents that the home and the lives of the normal people in that home cannot be built around the feeble-minded child. Parents of mentally defective children are not inclined to accept the diagnosis regardless of how thoroughly the case has been studied; or if they accept the diagnosis they are prone to seek every available source of help. This state of mind often leads to constant pursuit of a cure for something that is incurable. The emotionally overwrought parents feel that there must be an operation, a drug, or some bit of medical magic that will create or restore what never existed. This tragic and pathetic situation, however, is not alleviated by offering false hope. All too frequently parents devote their time and practically all their available money to building the home around the abnormal child. This deprives the normal children in the home of the opportunities to which they are entitled and at the same time creates in them jealousy, resentment, and other undesirable personality traits which prevent happy family relationships.

It is the duty of the clinic to see that physically and mentally healthy children with potentialities for worth-while achievements are not neglected because of the undue sentimentality of the parents for the mentally defective child. Whatever can be done for the defective child must be done by adequate methods of education and training. Direction as to how this training may be best obtained can be given by the clinic or other sources that are available in the community.

Extensive surgical and medical procedures are rarely called for after the child has had a careful physical examination and the necessary laboratory tests. In order to help these distraught parents to meet their problem in an intellectual rather than an emotional way and to safeguard the interests of the home, the clinic must present the problem to them with absolute frankness, regardless of how difficult such frankness may be.

The following case, although not belonging to the preschool group, is an example of what may happen to the mentally defective child who is also the victim of unintelligent parents and a sordid, immoral, poverty-stricken environment.

A girl 13 years of age was seen in jail while being held for trial because she had pushed a little boy 4 years old into the water, causing his death. The family background in this case was particularly bad; poverty, ignorance, and vice each played a part. For a long time the girl had been recognized as a menace to the community, and efforts had been made by the Society for the Prevention of Cruelty to Children to have her cared for in an institution. The mother, however, resented any interference from outside, and the case was allowed to drift along, one unhappy incident following another until this final tragedy, which demanded the attention of the law.

It was said that 2 years before, while bathing, this girl had held a youngster's head under water until the youngster was nearly drowned. A year before she had voluntarily had sexual relations with a man. At frequent intervals less serious incidents had been brought to the attention of the family and various social organizations.

In the psychological examination she graded at a mental age of 9½ years. Her emotional reaction during the examination, however, was a fair criterion of her irresponsibility.

When first visited in the jail she was very much concerned over the fact that she was being detained and could not go to the beach with her aunt. She showed little or no concern about the death of her playmate or about what would eventually happen to her. She did, however, manifest some anxiety over what the deceased lad's older sister would do to her, as the sister had threatened her before she had been sent to jail.

At the time of the next visit she was very much upset because she was not allowed to have the papers in order to read about herself and what had happened. It was almost impossible to hold her attention on any subject. She would constantly revert to the fact that "she wanted to read about herself and see what it said" and "the other prisoners who had the papers wouldn't permit her to see them." The lack of normal emotional response and the absence of concern regarding the youngster whose death she had caused are characteristic of many of the higher-grade mentally deficient individuals, and it is this insensitiveness to praise and blame and lack of ability to learn from previous experience which make them a menace to society and require some type of institutional training for an indefinite period. Many of these individuals, however, eventually become stabilized through institutional care and are able to make satisfactory adjustments in the community in later life.

This case was disposed of by commitment to an institution.

CONCLUSION

The material as presented indicates two things: First, that there is still much to be learned about the art of training children and that we are still in search of more adequate ways of overcoming undesirable habits and straightening out twisted personalities; and second, that there is an orderly, systematic, scientific approach to these problems which will produce increasingly satisfactory results as our knowledge advances.

Habits of eating, sleeping, and elimination are of fundamental importance in the development of the child's early life, and it is around these normal functions that many more serious difficulties occur in later life.

It has been pointed out that there are inherent differences in the way children are constituted mentally as well as physically. Therefore, it is not reasonable to expect all children to meet the same type of life situation in exactly the same way. In fact, it has been shown and demonstrated by case material that their responses may be very diverse. One child fights while another flees; one basks in the warmth of attention and affection while another is made self-conscious and uncomfortable by the same experience; Johnny worries over any minor deviation from the family moral code while Tommy rejoices in his success in outwitting his parents, his teacher, or the policeman. The point is that each child is in need of personal study and investigation, and no general scheme for handling problems of behavior is likely to be of any great value.

The attitudes of parents which may result from their own inadequate training and unhappy experiences in life have been shown to be among the most detrimental influences to the child during the formative years, and much that is of value in clinical and educational efforts results from helping parents with their own personal problems as they are reflected in their attitudes toward the children. One must continually remind those dealing with parents that it is not sufficient to point out the faults in their attitudes and techniques. They must also be made to understand why they persist in carrying out these attitudes in spite of the fact that they have been confronted with failure over a period of years. The point is that parents are quite unconscious of the fact that they are reacting on an emotional rather than on an intellectual level.

It is, therefore, important that the existing emotional attitude toward the child should not be exaggerated by the parents' visit to the clinic. It requires nice judgment to impress the parents with the necessity of giving serious consideration to the mental health of the child in order to avoid difficult problems later on while at the same time giving them understanding and confidence to replace worry and anxiety.

The responsibility for the mental health of the child must rest in the hands of parents, teachers, nurses, and the family physician. The same cooperative spirit in the management of the child's behavior as is evident in dealing with physical health and education will contribute much to the future happiness and efficiency of a large army of children who would otherwise embark upon life handicapped by habits, attitudes, and personality traits which result in delinquency, peculiar social behavior, antagonistic attitudes toward parents and society, and in an introspective, analytical approach to life where self is always so much in the foreground that it prevents the individual from getting the proper perspective of his environment as a whole. These distortions in outlook, when they are not caused by mental disease, are invariably the product of what the child has acquired from his early training and experience. Insofar as possible, it is the duty and responsibility of parents to see that the early career of the child is so guided and planned that he will avoid the shoals upon which many are wrecked.



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